

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

07327

1. DECEASED NAME (TYPE OR PRINT) Vincent F. Gasparovic			2a. DATE OF DEATH MONTH DAY YEAR 3 16 1987		2b. HOUR M
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 7 14 1918	6. AGE (IN YEARS (LAST BIRTHDAY)) 68 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2 N. Streeper St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter	12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Martin Gasparovic			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Roubal		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Anna Tweedale 4 N. Streeper St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible Ventricular arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, the (I) (we) last saw the deceased alive on <u>3/17/87</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. Sajadi</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/17/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>REZA SAJADI, M.D.</u>		22e. ADDRESS <u>100 N. BROADWAY BALTO. MD. 21231</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/87	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME B. Dabrowski & Son 2818 E. Baltimore St.			25a. DATE REC'D. BY REGISTRAR MAR 27 1987		
			25b. REGISTRAR'S SIGNATURE <u>Julia Dendorn-Rudner</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial certificate. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 2a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) STANLEY A. GEBHART					2a. DATE OF DEATH MONTH 03 DAY 30 YEAR 1987				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 03 DAY 25 YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7b. HOUR 9:45A MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) NEBRASKA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG.	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 48 OLMSTED GREEN #21210	
14. FATHER'S NAME FIRST FRANK MIDDLE GEBHART LAST				15. MOTHER'S MAIDEN NAME FIRST BERTHA MIDDLE EMRICH LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220-32-3661		17. INFORMANT ADDRESS MRS. LOUISE GEBHART 48 OLMSTED GREEN BALTO., MD 21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2° to Presumed Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Subdural Hematoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION 3-18-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural Hematoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. unknown 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) unknown					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 18, 1987 , to March 30, 1987 , that (I) (we) last saw the deceased alive on March 30, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kevin D. Judy				DEGREE MD				22c. DATE SIGNED 3-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin D. Judy				22e. ADDRESS Johns Hopkins Hospital, Balt., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APR. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE PIKEVILLE BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR APR 3 1987		25b. REGISTRAR'S SIGNATURE Davidson R. Lindsey			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07329

1. DECEASED NAME (TYPE OR PRINT) Edna		FIRST MIDDLE LAST Gee		2a. DATE OF DEATH MONTH DAY YEAR 3-2-87		2b. HOUR 12 ¹⁵ AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6-15-19		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berkland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLEANP.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 56 N. GORMAN AVE. 21223		14. FATHER'S NAME FIRST MIDDLE LAST George		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE Killie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS NORMAN ANDERSON 3528 CARRIAGE HILL CT.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pul arrest DUE TO, OR AS A CONSEQUENCE OF (b) CVA & Renal disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-11-87 19 to 3-2-87 19 that (I) (we) last saw the deceased alive on 3-2-19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Shah		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. SHAH		22e. ADDRESS 2105, N. Charles St Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-6-87		23c. NAME OF CEMETERY OR CREMATORY KING Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown MD	
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOME		ADDRESS 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR MAR 05 1987		25b. REGISTRAR'S SIGNATURE John London	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DR. G. 211411
G. 211411

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07330

1. DECEASED NAME (TYPE OR PRINT) Fauntleroy			2a. DATE OF DEATH MONTH DAY YEAR 3 26 87			2b. HOUR M AM			
3 SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR JAN. 20, 1901		6. AGE (IN YEARS (LAST BIRTHDAY)) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.			
10. CITY OR TOWN OF DEATH Balto., Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa St. Micheal Nursing Cen.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) n/a		12b. KIND OF BUSINESS OR INDUSTRY n/a	
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ALLEN GEE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY JONES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT ADDRESS 217-09-3847 MALCOLM GEE 4705 FOREST PK. AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-26 , 19 85 , to 3/26 , 19 87 , that (I) (we) lost saw the deceased alive on 3/4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Harold B. Lob MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-27-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD B. LOB MD			22e. ADDRESS 7220 Park Heights 21208						
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL			23b. DATE 3/30/87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD		
24. FUNERAL DIRECTOR NAME LEREOY O. DYETT 4600 LIBERTY HEIGHTS			ADDRESS 4600 LIBERTY HEIGHTS			25a. DATE REC'D. BY REGISTRAR MAR 30 1987			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

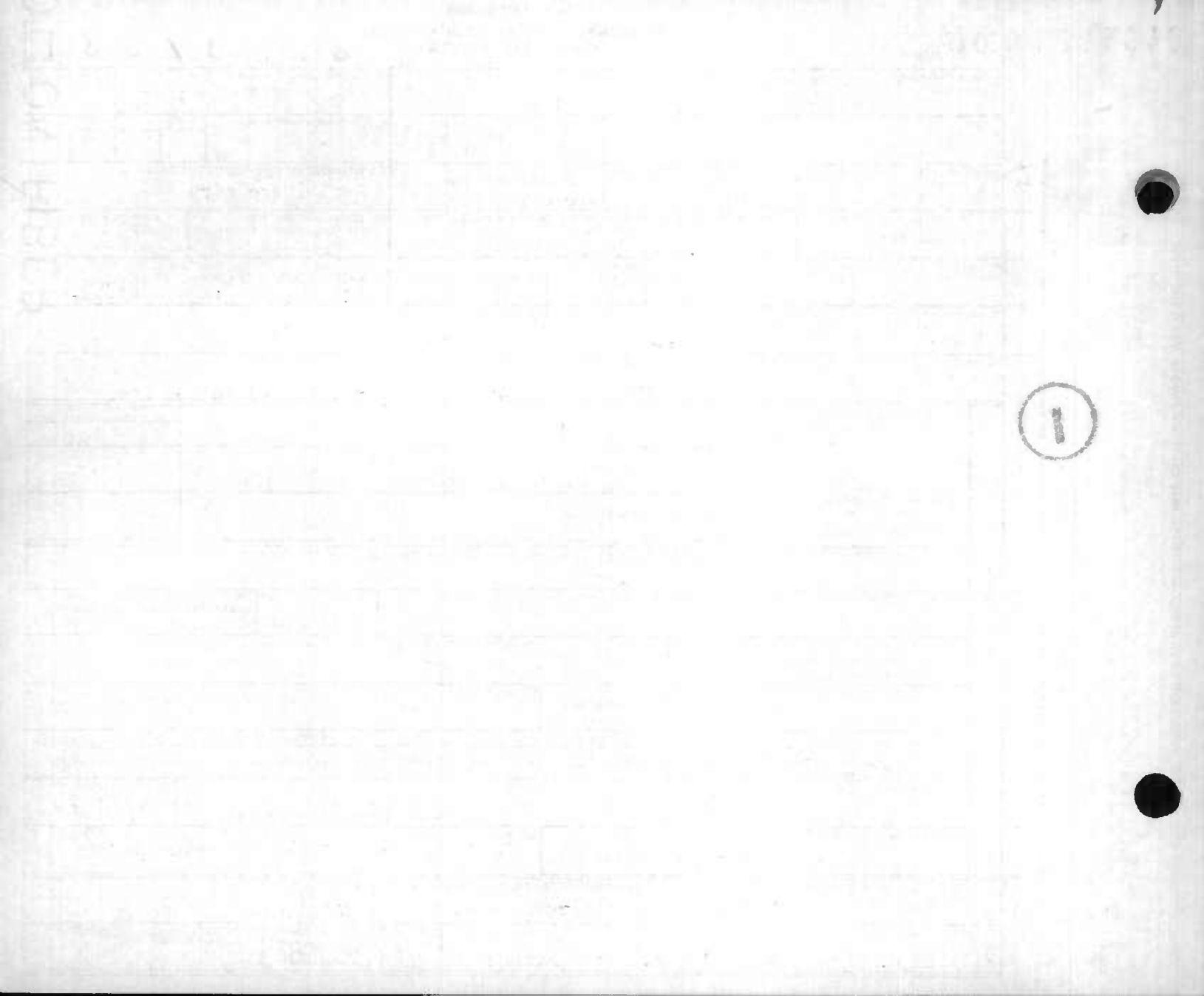
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please laminate containing pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. The medical examiner must be notified of a death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant conditions contributing to death but not related to the terminal disease or condition given in part 1, the medical examiner must be notified of a death.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07331

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph N. Gee			2a. DATE OF DEATH MONTH DAY YEAR 3 19 1987		2b. HOUR M
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 9 4 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 951 N. Washington Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Gee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 227-07-3349		17. INFORMANT ADDRESS Pauline Gee 951 N. Washington Street	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>adenocarcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>/</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 18 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>/</u>					
19a. DATE OF OPERATION <u>/</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>/</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>/</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>/</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>/</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1985</u> , to <u>March 1987</u> , that (I) (we) last saw the deceased alive on <u>Dec. 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>San Harrison</u>		DEGREE MD		22c. DATE SIGNED 3/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>San Harrison</u>		22e. ADDRESS <u>The Johns Hopkins Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md		24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Avenue			
25a. DATE REC'D. BY REGISTRAR MAR 26 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07332

1. DECEASED NAME (TYPE OR PRINT) Mildred A Gellner		2a. DATE OF DEATH MONTH DAY YEAR 3 26 87		2b. HOUR 8:40 A.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR July 12 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Clothing
13a. STATE MD.		13b. COUNTY BALTO	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Law		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Morrissy		13e. STREET ADDRESS / ZIP CODE 953 St. Agnes Lane 21207	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Charles R. Gellner 1211 Highland Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) multiple pressure ulcers DUE TO, OR AS A CONSEQUENCE OF (c) PVD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 31 Dec. 1986 , to March 26 1987 , that (I) (we) lost saw the deceased alive on March 21 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE JWR		DEGREE MD.		22c. DATES SIGNED 3/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JWR		22e. ADDRESS 611 S. CHAS ST. BALTO. MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-28-87		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Md.		25a. DATE REC'D. BY REGISTRAR MAR 30 1987			
24. FUNERAL DIRECTOR NAME JOHN M. WEBER & Sons Inc		ADDRESS 401 S. Chester		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 07333							
1. DECEASED NAME (TYPE OR PRINT) Margaret C. Gerner				2a. DATE OF DEATH March 4, 1987		2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 4, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Ret.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First: Bernhard Middle: Last: Gerner				15. MOTHER'S MAIDEN NAME First: Mary Middle: Last: Hafner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 163-28-4193		17. INFORMANT ADDRESS Helen Hubel 8625A Oakleigh Rd. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DEMENTIA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN JUDGING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINERS)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Luis E. Rivera M.D.				22e. ADDRESS 5714 Harford Road Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 7 1987		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION City or Town Yeadon		COUNTY STATE Penna.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Maryland		25a. DATE RECD BY REGISTRAR MAR 04 1987			
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 REG. NO. 07334	
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST VINCENT JOSEPH GIARDINA		2a. DATE OF DEATH MONTH DAY YEAR 3 16 87		2b. HOUR 0540M		
3a. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 10 19		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Drive/Salesman		12b. KIND OF BUSINESS OR INDUSTRY Brewery	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1104 Dorchester Avenue 21207			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Giardina				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anglina California							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES NO WW II		16b. SOCIAL SECURITY NO. 216-01-2594		17. INFORMANT ADDRESS Joseph V. Giardina 1933 Griffis Ave. 21230							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic CA of chondrosarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Resecting Bowel CA</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> , 19 <u>87</u> , to <u>3/16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>						DEGREE		22c. DATE SIGNED 3/16/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES K. ATKINS						22e. ADDRESS St. Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229						25a. DATE REC'D. BY REGISTRAR MAR 18 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the container with the other documents. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07335

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
James N. Gibson		3 20 87		7 45 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Black	MONTH DAY YEAR	62 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD. - U.S.A.	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Loch Raven V.A. Hosp.		Shipyard worker		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS / ZIP CODE			
13a. STATE COUNTY	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	607 Bartlett Av. 21218			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
First MIDDLE LAST	First MIDDLE LAST				
Willie Gibson	Mary				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
yes.	WW II	Hazel Gibson 716 N. Charles St. Apt. 908/21201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					48 hrs.
IMMEDIATE CAUSE (a) cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF					
(b) gram (+) septic shock					
DUE TO, OR AS A CONSEQUENCE OF					
(c) hepatorenal failure					~ 1 wk.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 17, 19 87, to March 20, 19 87, that (I) (we) lost saw the deceased alive on March 20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
B. Quintanilla MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		3/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Begoña Aristimuño		LRVAH Balt. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		3/24/87		GARRISON FOREST	
23d. LOCATION		23e. COUNTY		23f. STATE	
CITY OR TOWN		OWINGSMILLS		MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		MAR 23 1987		Alice Davidson-Randall	
MARCH FUNERAL HOME 1101 E. NORTH AVE.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other significant event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07336

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
MARY LEE GILBERT		3 5 87		2400M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	49 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	St. Agnes Hospital		Medical Secretary		Hospital
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. STREET ADDRESS / ZIP CODE		
13a. STATE		13b. COUNTY	13c. STREET ADDRESS / ZIP CODE		
Maryland		Baltimore	406 Third Avenue 21227		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Norman Adams, Sr.		Bertha Burke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		217-34-5516		C. David Gilbert 302 Tetra Ct. 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION (CLINICAL)					
DUE TO, OR AS A CONSEQUENCE OF:					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) PULMONARY EDEMA					
DUE TO, OR AS A CONSEQUENCE OF:					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
ADENOCARCINOMA OF THE OVARY WITH METASTASIS TO LIVER + LUNG					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NO: WHILE <input type="checkbox"/> AT WORK				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost					
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Michael E. Pelczar		MD		3/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MICHAEL E. PELCZAR MD		St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		3/9/87		Security Process Crem.	
24. FUNERAL DIRECTOR		24b. LOCATION		25a. DATE REC'D. BY REGISTRAR	
NAME		CITY OR TOWN COUNTY STATE		25b. REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc.		21229 Catonsville Baltimore Md.		MAR 09 1987 Julia Davidson-Randall	

BP

047059 MAR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07337

1. DECEASED NAME (TYPE OR PRINT) JANE S. GILL			2a. DATE OF DEATH MONTH DAY YEAR March 11, 1987			2b. HOUR 4:15 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 07 96		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Deaton Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Maryland Baltimore Reisterstown						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 408 Main St. 21136	
14. FATHER'S NAME FIRST MIDDLE LAST James _____ Jackson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane _____ Algire					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-28-0330		17. INFORMANT ADDRESS Betty J. Leppo 2712 Wildorlyn Dr. 21136					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular with gangrene</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Multifocal infarct dementia; Decubitus ulcers.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 24</u> 19 <u>84</u> to <u>March 11</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 5</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George Taler, M.D.</u>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <u>3/11/87</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George Taler, M.D.</u>				22f. ADDRESS <u>600 Light St. Balt. Md. 21230</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-14-87		23c. NAME OF CEMETERY OR CREMATORY Carroll Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Balto. Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home				ADDRESS Reisterstown, Md.		25a. DATE REC'D. BY REGISTRAR MAR 12 1987		25b. REGISTRAR'S SIGNATURE <u>Asia Robinson-Ridgely</u>	

18 3 6

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048540 MAR 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO 07338

1. DECEASED NAME (TYPE OR PRINT) IKESHIA			2a. DATE OF DEATH MONTH DAY YEAR MARCH 23, 1987			2b. HOUR 5:14P M					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 27 86		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 9 23		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1506 N. Ellwood Avenue 21213		
14. FATHER'S NAME FIRST MIDDLE LAST Harold Gilliard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Constance NOBIE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A	
17. INFORMANT ADDRESS Harold Gilliard, Sr. 1506 N. Ellwood Ave 21213			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS 2 WEEKS			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: VENTRICULAR SEPTAL DEFECT, DOWN'S SYNDROME					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-26- 19 87 , to 3-23- 19 87 , that (I) (we) lost saw the deceased alive on 3-23- 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Janet A. Nagel, M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/23/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JANET A. NAGEL			22e. ADDRESS JOHNS HOPKINS HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 3/27/87		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL MD.				
24. FUNERAL DIRECTOR NAME ADDRESS MARCH FUNERAL HOME 1101 E. NORTH AVB.			25a. DATE REC'D. BY REGISTRAR MAR 26 1987			25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take the whole certificate to the State Dept. of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

SECRET

CONFIDENTIAL

TOP SECRET



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR
STATE
REGISTRAR

REG. NO. **87-7332**

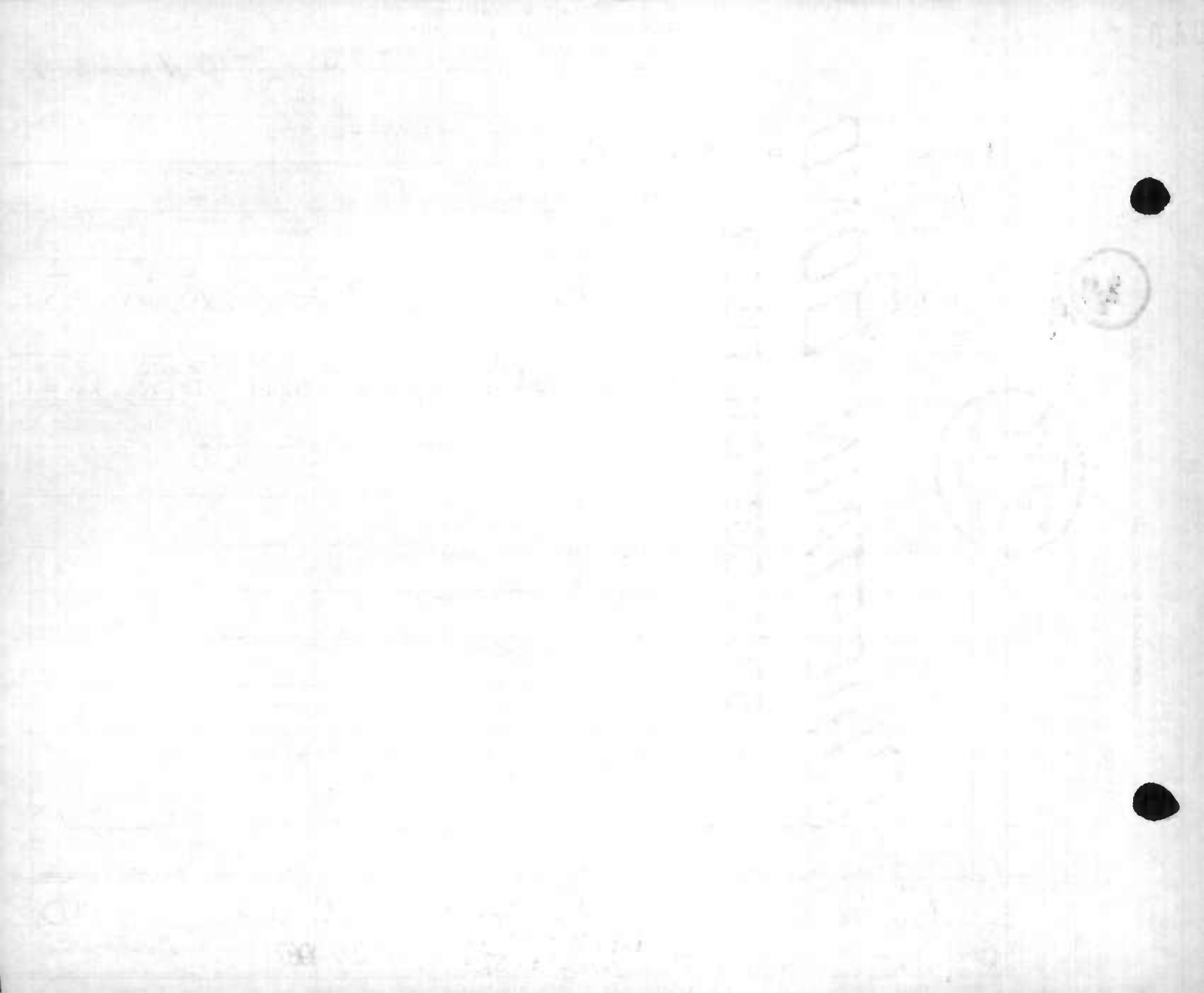
1. DECEASED NAME (TYPE OR PRINT) Lucille Gilliard			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 3 YEAR 22 1987			2b. HOUR 3 AM			
3. SEX Female	4. RACE B	5. DATE OF BIRTH MONTH 4 DAY 27 YEAR 1908	6. AGE (IN YEARS) 86 YRS.	IF UNDER 24 HRS. MONTHS _____ DAYS _____ HOURS _____ MIN _____	7c. DATE PRONOUNCED DEAD MONTH 3 DAY 22 YEAR 1987	2d. HOUR 3 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2020 Division Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.			13b. COUNTY		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST E. J. A. MIDDLE _____ LAST Evans			15. MOTHER'S MAIDEN NAME FIRST _____ MIDDLE _____ LAST _____			16. ADDRESS 2020 Division St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 220-30-1183A		17. INFORMANT Rev. Reginald Gilliard			ADDRESS 2020 Division St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) disease with cerebrovascular accident (stroke) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John E. Smialek</i>			TITLE (SPECIFY) Chief			MEDICAL EXAMINER			DATE SIGNED 3/24/87
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.			ADDRESS 111 Penn St. Balto., MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-27-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN BALTO. COUNTY _____ STATE MD		
24. FUNERAL DIRECTOR NAME Brown-Rotomski ADDRESS 1913-15 W. BALTO. ST.			25a. DATE REC'D. BY REGISTRAR MAR 26 1987			25b. REGISTRAR'S SIGNATURE <i>John Davidson Handell</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA-100, PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. These pages should be attached to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene and the local health department.

IMPORTANT: If item 21 is marked on item 18 above, any delay in filing this certificate with the local health department will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 07340					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY GILLIS JR				2a. DATE OF DEATH MONTH DAY YEAR MARCH 3, 1987				2b. HOUR 9:10P M	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 5 26 24		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Balto. Dandalk				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 305 Avondale Rd. 21222			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Gillis Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia Gillis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
16b. SOCIAL SECURITY NO. 225-20-6764		17. INFORMANT ADDRESS Mrs. Martha Gillis 305 Avondale Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>inanition</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous cell cancer of tongue</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute 10 weeks 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <u>Jan 24</u> , 19 <u>87</u> , to <u>March 3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William S. Aronstein</u>				DEGREE MD				22c. DATE SIGNED 3-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARONSTEIN				22e. ADDRESS 600 N WOLFE ST THE JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial				23b. DATE 3-8-87		23c. NAME OF CEMETERY OR CREMATORY Shiloh Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fredericksburg Va.	
24. FUNERAL DIRECTOR NAME Jas. A. MORTON & SONS				ADDRESS 1701 LAURENS		25a. DATE REC'D. BY REGISTRAR MAR 06 1987		25b. REGISTRAR'S SIGNATURE <u>John Anderson-Randall</u>	

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046965 MAR 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Eric ERIC T. GILLUMS					2. DATE OF DEATH MONTH 2 DAY 26 YEAR 87 26 HOUR 5:48 PM				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 11 DAY 28 YEAR 52		6. AGE (IN YEARS (LAST BIRTHDAY)) 34 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chef		12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1300 Division Street 21217	
14. FATHER'S NAME FIRST Earl MIDDLE - LAST Gillums		15. MOTHER'S MAIDEN NAME FIRST Dorothy MIDDLE - LAST Gregory							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1970		17. INFORMANT sister ADDRESS Woodbridge, VA. Darcella Sewell-1630 Woodside Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Failure DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic DUE TO, OR AS A CONSEQUENCE OF (c) Hepatic B Chronic Persistent APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Intensive Drug Abuse									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/16 , 19 87 , to 2/26 , 19 87 , that (I) (we) last saw the deceased alive on 2/26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 2/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kovitz		22e. ADDRESS University of Maryland Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/4/87		23c. NAME OF CEMETERY OR CREMATORY Arlington, NATIONAL CEMETERY, ARLINGTON, VA		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE		ADDRESS 2617 Pa Ave SE Wash DC		25a. DATE REC'D. BY REGISTRAR MAR 09 1987					
				25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove copy to page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the death papers, Pages 1, and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic cause, the medical examiner must file notification.

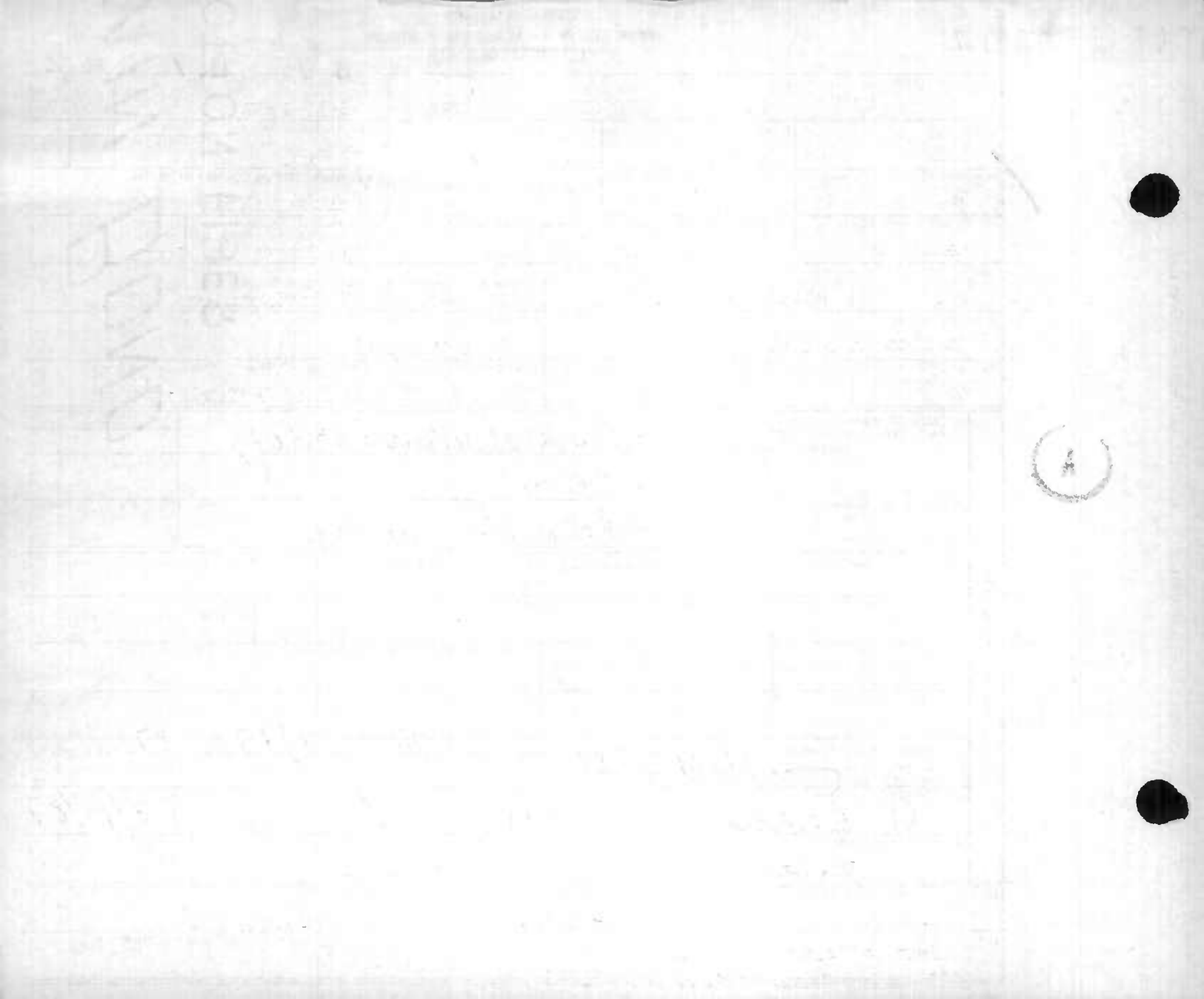
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07342

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN B. GIORGILLI SR.			2a. DATE OF DEATH MONTH DAY YEAR 3-17-1987		2b. HOUR am 10:17			
3. SEX male		4. RACE cauc.		5. DATE OF BIRTH MONTH DAY YEAR 10-14-1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 yrs. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY Local #1	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 6927 Chambers Road 21234				
14. FATHER'S NAME FIRST MIDDLE LAST Americo Giorgilli				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Vendetti				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-9947A		17. INFORMANT ADDRESS Virginia Giorgilli 6927 Chambers Road 21234				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Shock of exsanguination DUE TO, OR AS A CONSEQUENCE OF (b) - COPI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) - Respiratory failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE OR CONDITION GIVEN IN PART 1: a								
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			9c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		9d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/12/87 19 87 , to 3/17 19 87 , that (I) (we) last saw the deceased above , (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE G. Radon				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Radon				22e. ADDRESS G.B.M.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-20-87		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR Schmunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213				25a. DATE REC'D. BY REGISTRAR MAR 20 1987				
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the above pages from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1. STATE 7. REGISTRAR		Item #1 5 & 6 G 626 4/1/87 CW	STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 7 REG. NO. 0 7 3 4 3
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAMELA E. GLENN			2a. DATE OF DEATH MONTH DAY YEAR 3/26/87		2b. HOUR 12:41 AM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 8/1/52		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 33 34	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN WASHINGTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena TUCKER		13e. STREET ADDRESS / ZIP CODE 727 E. 22nd St. / 21218	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-62-8708		17. INFORMANT ADDRESS DAVID GLENN 727 E. 22nd St. / 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) OVERWHELMING Sepsis					DAYS
DUE TO, OR AS A CONSEQUENCE OF (c) BLAST CRISIS of Chronic myeloid leukemia					DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC MYELOID LEUKEMIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <input checked="" type="checkbox"/> (the hospital) attended the deceased from 2/16 19 87 , to 3/26 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 3/26 19 87 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE Michael E. Kloftas MD		DEGREE MD		22c. DATE SIGNED 3/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael E. Kloftas MD		22e. ADDRESS 3001 S. Hanover St. Baltimore, MD 21232			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Mar 27 1987		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D BY REGISTRAR MAR 27 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

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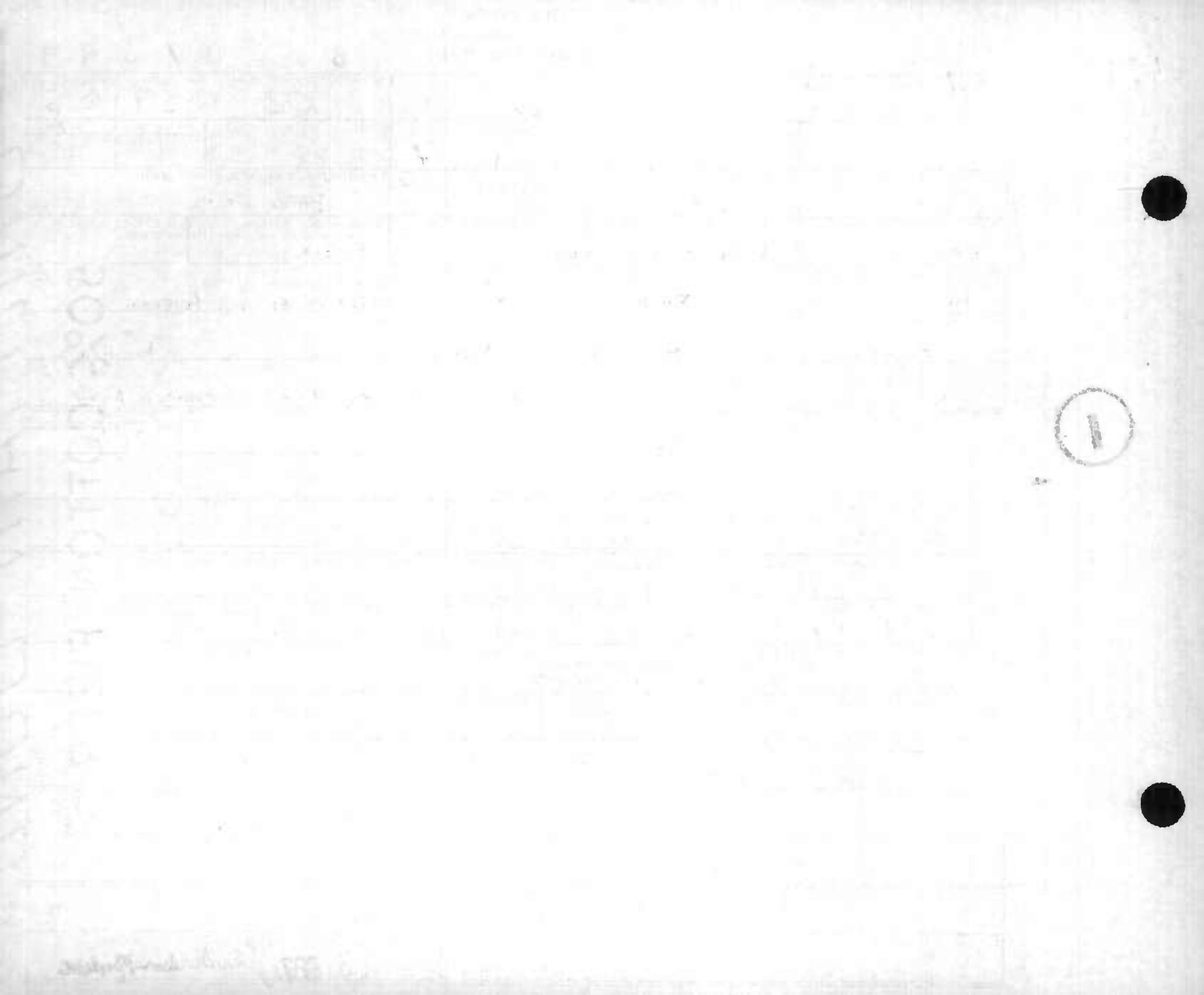
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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove covering papers, pages 4 and 5, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div> <div>4</div> <div>047167 MAR</div> <div>FOR 1- STATE REGISTRAR</div> <div>REG. NO. 87 07344</div> </div>									
1. DECEASED NAME (TYPE OR PRINT)			FIRST (Annie) MIDDLE LAST ANNIE GLOVER			2a. DATE OF DEATH MONTH DAY YEAR 03 10 87		2b. HOUR MIN. 10 P.M.	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 2 1 24		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR IF UNDER 1 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) F.S.K.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO.		13e. STREET ADDRESS / ZIP CODE 4723 WRENWOOD AVENUE 21212			
14. FATHER'S NAME FIRST MIDDLE LAST Brooks Murray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mullens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. unk		17. INFORMANT ADDRESS Charles Harvey 4723 Wrenwood Ave. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>unknown</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>sepsis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>intestinal lymphoma</u>									
19a. DATE OF OPERATION 3/6/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal perforation				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1020 A.M. 3 10 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/5/87</u> to <u>3/10/87</u> , that (I) (we) lost saw the deceased alive on <u>3/10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d/d) did not view the body after death.									
22b. SIGNATURE Bastidas				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASTIDAS				22e. ADDRESS FSKMC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/16/87		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY		23d. LOCATION CITY OR TOWN COUNTY ANNE ARUNDEL MD			
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOME 1101 E. NORTH AVE.				25a. DATE REC'D. BY REGISTRAR MAR 13 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any of the following conditions, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87 REG. NO. 07345							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A			
IDA		M. GOELLER		MARCH 14, 1987		2:30		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		JUNE 15 1920		66		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.		U.S.A.				BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		HOMEMAKER					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD.				BALTIMORE				628 N. Highland Ave. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
ALOYS		SIEWIERSKI		JULIA		KAMUDA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		212-18-5019		ADAM GOELLER (HUSBAND)		SAME ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>GASPOUNDRIN BURN</u>		48°							
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Thrombocytopenia</u>		72°							
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Lymphoma</u>		47°							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3/6/87		PREPARED GASME NEED							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> , 19 <u>87</u> , to <u>3/14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED					
		BRIAN J WADS		3/14/87					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY			
BURIAL		3/16/87		SACRED HEART OF JESUS		BALTIMORE		MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SCHUMNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213		MAR 17 1987							

048652 MAR 31

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 97345

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick Goff			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3/ 26/ 19 87			2b. HOUR 2:45 P M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 10 61	6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3/ 26/ 19 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Cem. Druidridge
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Willie Harper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazeltime			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		
16b. SOCIAL SECURITY NO.			17. INFORMANT Name Batts			ADDRESS 3212 Gwynns Falls Pkwy.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral Trauma 8122 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 1:00 P.M. 3/25/ 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject motorcyclist/fixed object/auto impact			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Park Hgts at Park Circle, Balto. City, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE William M. Zane			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 3/27/87		
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.			ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/30/87		23c. NAME OF CEMETERY OR CREMATORY Druidridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H West					ADDRESS 4300 Wabash Ave.		25a. DATE REC'D. BY REGISTRAR MAR 30 1987	
					25b. REGISTRAR'S SIGNATURE [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOUIS GOLD			2a. DATE OF DEATH MONTH DAY YEAR March 25, 1987		2b. HOUR 2:09 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APR. 14, 1896	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5715 PARK HTS. AVE., APT. 809		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER	12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE APT. 809 5715 PARK HTS. AVE. 21215	
14. FATHER'S NAME FIRST MIDDLE LAST HYMAN GOLD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEAH UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-8381	17. INFORMANT MRS. HELENE CROSS, APT. 205 3860 N.E. 170TH ST. N. MIAMI BEA., FL 33160		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic liver disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon Ca</u>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Ascites with previous MI

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>3/24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Allen Hettlemen</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allen Hettlemen</u>		22e. ADDRESS <u>1777 Reisterstown Rd 21208</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAR. 27, 1987	23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR MAR 31 1987	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the certificate must be submitted to the State Department of Health and Mental Hygiene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 7 0 7 3 4 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL GOLDBERG					2a. DATE OF DEATH MONTH DAY YEAR 3/19/1987			2b. HOUR 350 A M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 08 07 00		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALT.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL			
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. ZIP CODE 21208			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-3463		17. INFORMANT MR. JOEL ZILMAN 8331 SCOTTS LEVEL RD. BALTO., MD 21208							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF, (b) pneumal effusion, pulm. edema, heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CHF, HTN APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/3 , 19 87 , to 3/19 , 19 87 , that (I) (we) last saw the deceased alive on 3/19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE D. Boersma MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. BOERSMA				22e. ADDRESS SINAI HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 22, 1987		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR MAR 27 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Parker</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87 REG. NO. 07349							
1. DECEASED NAME (TYPE OR PRINT) OLIVE G. GOLDSBOROUGH				2a. DATE OF DEATH MONTH DAY YEAR March 14, 1987		2b. HOUR a m 2:28			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? Canada		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 A. Cross Keys Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Dress Shop	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6 A. Cross Keys Rd., 21210	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Bamford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Erskine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 42 3943		17. INFORMANT ADDRESS Joseph U. Goldsborough, Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO MA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 14</u> 19 <u>74</u> , to <u>MARCH 14</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>MARCH 13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alexis M. Menendez</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCO M. MENENDEZ, M.D.				22e. ADDRESS 5820 YORK RD BALTO MD 21212					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/17/87		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				25a. DATE REC'D. BY REGISTRAR MAR 16 1987		25b. REGISTRAR'S SIGNATURE <u>meurdon-Randall</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, the attending physician and the funeral director must sign and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit and also on the death certificate. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, the death certificate event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07350 | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Anna Goldstein</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>03-30-87</i> | | 2b. HOUR
<i>1045P M</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>03-06-1898</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
<i>89 YRS.</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Russia</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Levinthal</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>AT HOME</i> |
| 13a. RESIDENCE (IF TRAVELING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
<i>MARYLAND</i> | 13b. COUNTY
<i>BALTO.</i> | 13c. CITY OR TOWN
<i>BALTO.</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<i>9 OAK HOLLOW CT. #21208</i> | |
| 14. OTHER'S NAME
FIRST MIDDLE LAST
<i>LOUIS KRAUSE</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>MINNIE VERNITSKY</i> | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
<i>NO</i> | | | 17. INFORMANT
NAME ADDRESS
<i>MRS. IRENE GOLDBLIN
9 OAK HOLLOW CT. BALTO., MD 21208</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>3:30 P.M. 19 87</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/20</i> 19 <i>87</i> , to <i>3/30</i> 19 <i>87</i> , that (we) last saw the deceased alive on <i>3/30</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>E. Estrelita</i> | | DEGREE
<i>M.D.</i>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>3/31/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ESTRELITA O. KU</i> | | 22e. ADDRESS
<i>KEVINDAVE HEBREW GERIATRIC CENTER + HOSPITAL</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>APR. 1, 1987</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>BETH YEHUDA ANSHE KURLAND</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTIMORE MARYLAND</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>SOL LEVINSON & BROS., INC.</i>
<i>6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | 25. DATE REC'D. BY REGISTRAR
<i>APR 3 1987</i> | | |
| 25b. REGISTRAR'S SIGNATURE
<i>John R. Rude</i> | | | | | |

BP

AREA - 11110000
SE-20-20-11
11110000

004 04-

007-11

004 04- 007-11 11110000

046244 MAR 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages 1 and 2 to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William F. Goldstraw, sr. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR March 2, 1987 | | | 2b. HOUR
M A | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR April 5, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
211 W. McGomas St. Balto. Md. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Pet. painter | | 12b. KIND OF BUSINESS OR INDUSTRY
Render | | |
| 13a. STATE
Maryland | | 13b. COUNTY
----- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
211 W. McGomas St. Balto. Md. 21230 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James R. Goldstraw | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary F. Peterson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-03-5852 | | 17. INFORMANT
ADDRESS
Mrs. Dorothy C. Goldstraw, same as above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
12 | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
OBSTRUCTIVE LUNG DISEASE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-26 , 19 87 , to 3-2 , 19 87 , that (I) (we) last saw the deceased alive on 2-26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Marc Posner, MD. | | | | | 22e. ADDRESS
107 E. West St. Balto. Md. 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/4/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemt. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. A.A. Co. Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Baltimore, Md. 21230
McCully Funeral Home, 130 E. Port Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 05 1987 | | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's stamp. Page 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / REG. NO. 07352

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELIZABETH GOODE | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 27, 1987 | | 2b. HOUR
7:39 A.M. | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6 13 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemp. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEE Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218072149A | | 17. INFORMANT
ADDRESS
Edward Gilchrist, 1904 E. Federal St. 21213 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Recent myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Severe coronary artery disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 min.
2 days
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary edema | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 87 , to 3/27 , 19 87 , that (I) (we) lost
saw the deceased alive on 3/26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
2 K H
DEGREE | | | | 22c. DATE SIGNED
3/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mun Hong, MD | | | | 22e. ADDRESS
JHH | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus MD | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH Funeral Home | | ADDRESS
1101 E. NORTH AVE. | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rodman | |

MEDICAL CERTIFICATION

1



047553 MAR 1987

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JUNIOUS K. GOODE | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 16, 1987 | | 2b. HOUR
4:10A M | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 6 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BETH. STEEL | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2526 CHASE STREET 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT GOODE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELSIE LEE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
YES | | 16b. SOCIAL SECURITY NO.
213090040 | | 17. INFORMANT
ADDRESS
LILLIAN GOODE 1016 N. MONROE ST. 21217 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>esophageal cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Approximate interval between onset and death
<u>5 minutes</u>
<u>4 months</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 9, 19 87</u> , to <u>March 16, 19 87</u> , that (I) (we) lost
saw the deceased alive on <u>March 16, 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Julie Z. Livingston</u> | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Julie Z. LIVINGSTON | | | | 22e. ADDRESS
600 N. Wolfe St Baltimore, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
BURIAL | | 23b. DATE
3/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILL, MD | | 23e. DATE REC'D. BY REGISTRAR | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

29

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by a physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased must be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1060 DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10 JUN 1950

1 011 SP 30

4:30

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **07354**

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|-----------------------------------|--|-------------------------|--|--------------------------|--|--------------------------------------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Robert | | Floyd | | Goodman | | | | 3 | | 11 | | 19 | | 87 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | Black | 1-19 24 | | 63 | | MONTHS | | DAYS | | 3 | | 11 | | 19 | | 87 | | 8:15P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| North Carolina | | USA | | YES | | X | | NO | | NO | | Baltimore City, | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | 3440 Reisterstown Road | | Post Office | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE (CITY LIMITS?) | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | | | Baltimore | | YES X NO | | 918 Kevin Rd. 21229 | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Alston | | Goodman | | Maggie | | Blue | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| Yes | | 241-24-0611 | | Queen Esther Goodman | | 918 Kevin Rd. | | | | | | | | | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | |
| (b) _____ | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) _____ | | | |

| | | | |
|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| | | | |
| 20. AUTOPSY? | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | |

| | | | |
|---|--|--|--|
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | |
| | | M.D. Assistant MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) | | DATE SIGNED | |
| William M. Zane, M.D. | | 3/12/87 | |
| ADDRESS | | | |
| 111 Penn St. Balto. MD. | | | |

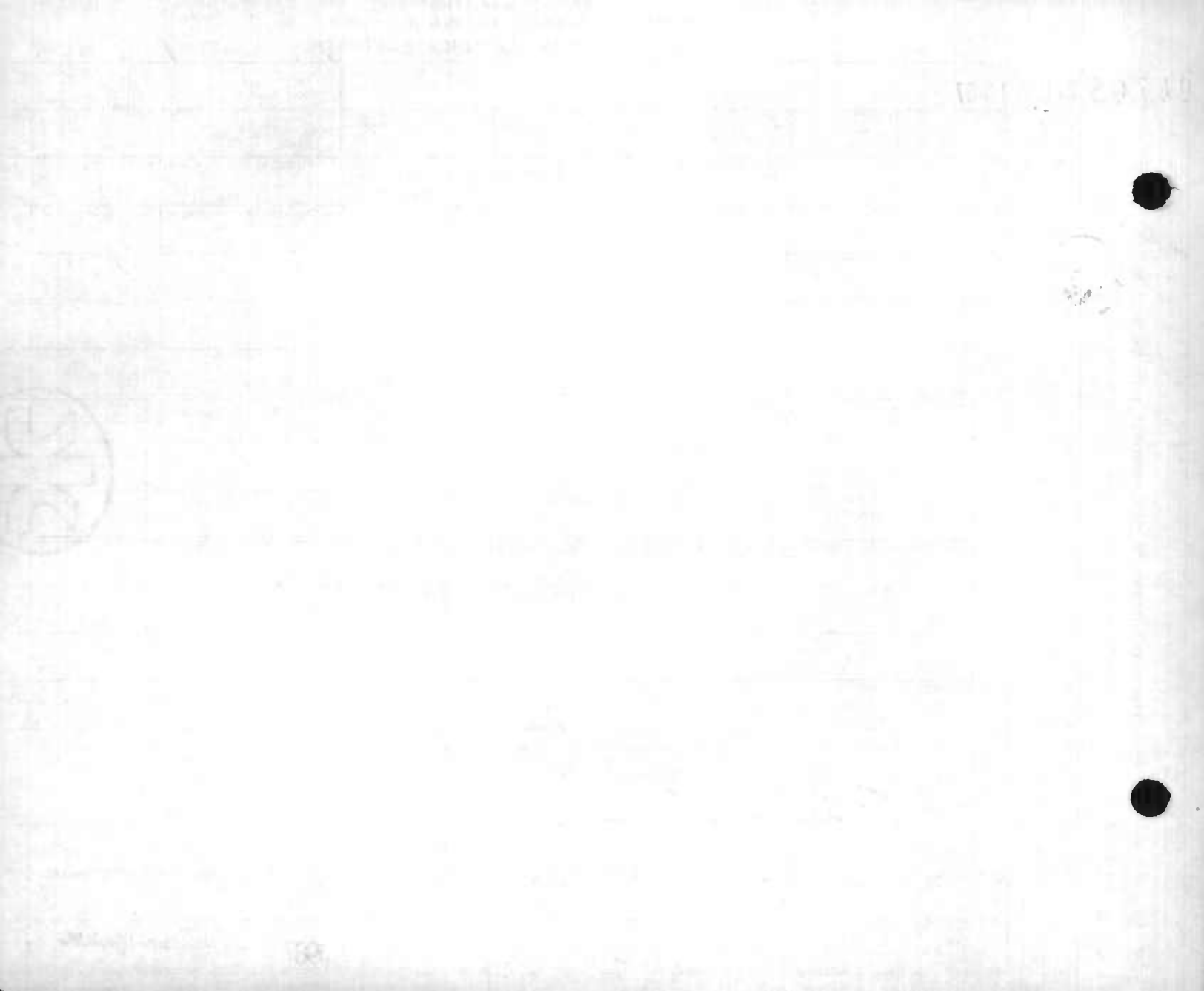
| | | | | | | | |
|---|--|------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 3/23/87 | | Garrison Forest Vet. Cem. | | Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm C March F/H West | | 4300 Wabash Ave. | | MAR 17 1987 | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 REG. NO. 07355
2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR P
MARCH 16, 1987 4:20 P

| | | | | |
|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
NATALIE GORDON | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 16, 1987 | | 2b. HOUR P
4:20 P |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 24 67 | | 6. AGE (IN YEARS LAST BIRTHDAY)
20 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Gordon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elinor Jones | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-90-0582 | 17. INFORMANT ADDRESS
wm. Gordon 4 Tricount Ct. | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: ASTROCYTOMA
IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|--|---|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 4</u> , 19 <u>87</u> , to <u>march</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>MARCH 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
B Nagpal | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BEENA K NAGPAL MD. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | |

| | | | |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
3-20-87 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
A.A. Co. MD. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
BROWN-TOMPSON Fun. Home 1913-15 W. Balto. ST | | 25a. DATE REC'D. BY REGISTRAR
MAR 19 1987 | 25b. REGISTRAR'S SIGNATURE
Lisa Gordon-Landree |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in-32 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
JAN 10 1910
U.S. DEPT. OF AGRICULTURE

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

[Faint handwritten text at the bottom of the page, possibly a signature or date.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove it to the Division of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1 and 2 should be filed with 72 hours after death.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07356

| | | | | | |
|---|-------------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVA VIRGINIA GOSNELL | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 24 87 | | 2b. HOUR
355 PM | |
| 3. SEX
F | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 29 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Maryland | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Sykesville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elmer Dixon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Olivia Harrison | | 16. ADDRESS
Springfield State Hospital | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 17b. SOCIAL SECURITY NO.
213-24-8010 | | 17c. INFORMANT
Springfield State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (c) Gut cell Carcinoma of lung
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
PM 19 | | 20c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
(STREET CITY OR TOWN COUNTY STATE) | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/23/87 19 to 3/24/87 19 that (I) (we) last saw the deceased alive on 3/24/87 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Quian Galarraga MD | | 22c. ADDRESS
SINAI Hospital | | 22d. DATE SIGNED
3/24/87 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
GALARRAGA | | 22f. ADDRESS
SINAI Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
03-30-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Airy Chapel | |
| 23d. LOCATION
(CITY OR TOWN COUNTY STATE)
Mt. Airy Carroll MD | | 23e. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
Haight Funeral Home | | 24b. ADDRESS
Sykesville, MD | | | |
| 24c. REGISTRAR'S SIGNATURE
Julia Davidson-Rendell | | 24d. DATE
MAR 31 1987 | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the permit papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Agnes Tucker Grace | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 28 87 | | | 2b. HOUR
M
M | | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 24 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
819 Lyndhurst Ave. 21229 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joshua Collier | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Joanne Manning | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
- 223-16-0743 | | 17. INFORMANT
ADDRESS
Mary L. Barnes 5420 Parker St. 23231 Richmond Va. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>July 1</u> 19 <u>85</u> to <u>MARCH 28</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>November</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Patricia L. Garver</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<u>3/30/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>PATRICIA L. GARVER</u> | | | | | 22e. ADDRESS
<u>600 N. Wolfe St Balt. 21205</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Md. | | | |
| 24. FUNERAL DIRECTOR
Wm C. March F/H West 4300 Wabash Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 2 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Swickard-Rudner</u> | | | |

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555 NORTH W. 5th St.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07359

| | | | | | |
|---|--|---|--|---|-------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
WORTH GRAHAM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 14 87 | | 2b. HOUR
MIN.
547 P. M. |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
3 22 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GENERAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FORK LIFT OPERATOR | |
| 12b. KIND OF BUSINESS OR INDUSTRY
KOPPERS CO. | | 13a. STREET ADDRESS / ZIP CODE
BALTO, MD.
3028 SEAMON AVE. 21225 | | | |
| 13b. STATE
MARYLAND | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD GRAHAM | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESSIE MASSEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-05-9729 | | 17. INFORMANT
MRS. BALTIMORE, MD, 21225
OPHELIA GRAHAM 3028 SEAMON AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) ATRIAL FIB C VT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) BRONCHOPNEUMONIA C CONGESTION | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
ALVEOLAR CA OF LUNG | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | |
| 21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 21e. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21f. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/25 19 87 to 3/14 19 87, that (I) (we) lost
saw the deceased alive on 3/14 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Chubach North 40 | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/19/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUSUS MEM. PARK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | 24. FUNERAL HOME
NUTTER + SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PKWY. BALTO, MD. 21216 | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | |
| 25b. REGISTRAR'S SIGNATURE
Lisa E. Anderson | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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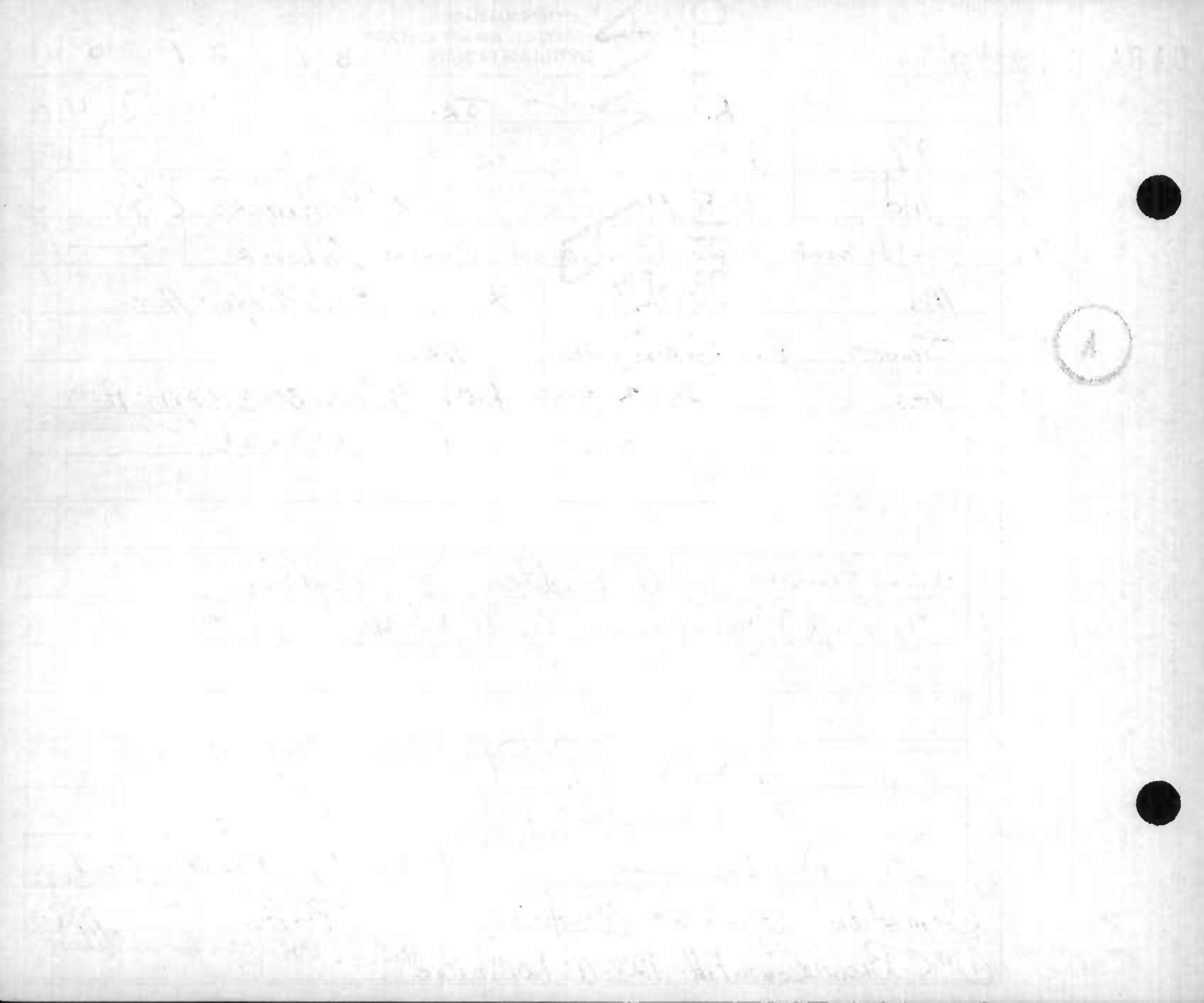
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a copy should be filed in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>James R. Grant JR.</i> | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 20 87</i> | | 2b. HOUR
<i>4:15 PM</i> | | |
| 3. SEX
<i>M</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 28 33</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>54</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY)
<i>MD.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Liberty Medical Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Laborer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>MD.</i> | | 13b. COUNTY
<i>Balto.</i> | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>3003 Wayne Ave. 21207</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>James R. Grant SR.</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Ruth</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | | | 16b. SOCIAL SECURITY NO.
<i>216-28-8989</i> | | 17. INFORMANT
ADDRESS
<i>Ruth Wilson 3003 Wayne Ave.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardioresp. arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
<i>gangrenous gall bladder & sepsis</i> | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>3/13/87</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>gangrenous Gall bladder</i> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/20/87</i> 19 <i>87</i> to <i>3/20/87</i> 19 <i>87</i> that (I) (we) lost saw the deceased alive on <i>3/20/87</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>J. Brown MD</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Dr. J. Brown</i> | | | | 22e. ADDRESS
<i>Liberty Med. Center</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
<i>CREMATION</i> | | 23b. DATE
<i>3-25-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Westview</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Balto. MD.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Wm C. Brown</i> | | | | ADDRESS
<i>Conn. Fitt 1206 W. North Ave.</i> | | 25a. DATE RECD. BY REG. OFF. MAR 27 1987 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from the certificate, and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is checked or item 18 shows any injury or other traumatic cause of death, the medical examiner must be notified of one.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07361

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE W. GRAVES | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 12 87 | | 2b. HOUR
2:30 AM | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 20 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
North Carolina Public Schools | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALBERT BROWN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose GRAVES | | 13e. STREET ADDRESS / ZIP CODE
3017 Walbrook Ave 21216 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
009-48-6232 | | 17. INFORMANT
Emma Haugh 2619 Cybuen Ave. 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE MYOCARDIAL INFARCTION
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15
4 hrs
4 hrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Peripheral vascular insufficiency | | | | | | | |
| 19a. DATE OF OPERATION
3/11/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Foot Cancer | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3/11/87 3/12 1987 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
V. M. K. Hill | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/12/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. Hill | | 22e. ADDRESS
SINAI | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Church Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Durham, North Carolina | |
| 24. FUNERAL DIRECTOR
NAME
W.C. March F/H West 4300 Wabash Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Rodriguez | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

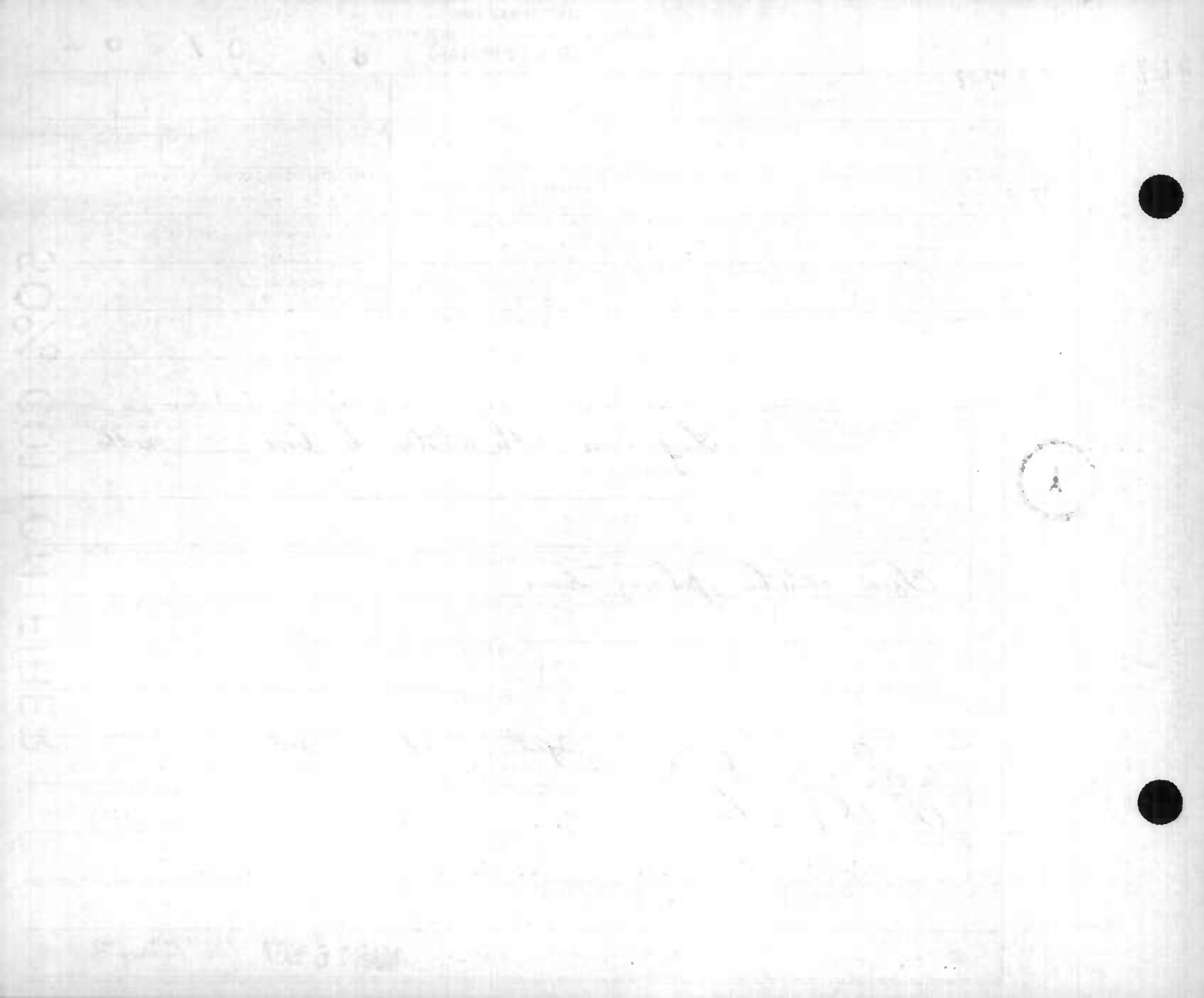
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07362

| | | | | | |
|--|--|--|---|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | M | |
| John Green | | 3 12 87 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| male | black | MONTH DAY YEAR | 68 | IF UNDER 24 HRS | |
| | | | | MONTHS | DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| S.C. | U S A | | Baltimore city MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTO. | 2517 E. Chase Street | | N/A | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
| MD | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2517 E. CHASE ST. 21213 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| JOHN GREEN | | AMELIA EVANS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES | | 251162839 | | CELESTINE VAUGHAN 2517 E. CHASE ST. 21213 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lung cancer with metastasis to liver</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Chronic obstruction pulmonary disease</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>August</u> , 19 <u>86</u> , to <u>now</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive above <u>Jan. 5</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Chi-Shiang Chen</u>
DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Chi-Shiang Chen, M.D. | | 100 N. Broadway Balto., MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 3/17/87 | | GARRISON FOREST | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm. C. March F/H 1101 E. North Avenue | | MAR 16 1987 | | <u>Julia Davidson-Rudolph</u> | |

BP



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07363
REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--------------------------------------|--|-------------------|--|-----------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| OLIVER HUGER GREEN, Sr. | | | | | | | | 03 | | 11 | | 87 | | | | 057 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Male | | Black | | 05 07 25 | | 62 | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| BALTO. - CITY | | USA | | | | CITY | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| BALTO. - CITY | | SINAI - HOSP. - BALTIMORE | | Truck Driver | | | | | | | | | | | | | |

| | | | | | | | | | | | |
|---|--|--|--|------------------|--|-------------------|--|---|--|-----------------------------------|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| BALTO. - CITY | | MARYLAND | | BALTIMORE | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2911 ROSALIND AVE BALTO, MD 21215 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Oliver | | Rosalie | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| Unknown | | 249-30-6951 | | Oliver Green Jr. | | 2911 Rosalind Ave | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiogenic shock

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 3/10 19 87, to 3/10 19 87, that (I/we) lost saw the deceased alive on 3/10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| | | Dr. S. Ross | | | | 3/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| S. ROSS | | Sinai-Hospital, Baltimore, MD | | | | | |

| | | | | | | | |
|---|--|-----------|--|------------------------------------|--|----------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 3/16/87 | | Md. Vet. Cem. | | CITY OR TOWN COUNTY STATE | |
| | | | | | | Crownsville, Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME C March F/H West 4300 Wabash Ave. | | | | MAR 17 1987 | | [Signature] | |

72473

1

047513 MAR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. COMPLETE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP 524
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07364 | |
|---|------------------|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Robert E. Green | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 8 1987 | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR 11 29 30 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 56 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 3 8 1987 | 2d. HOUR
1:12 P.M. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ins. Agent | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Westminster | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
404 Monterey Drive 21157 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Morris Green | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hazel L'Rue | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
ADDRESS
Miriam J. Green 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Common bile duct obstruction with complications</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <u>Cholelithiasis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE
<i>Charles P. Kokes</i> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 3-9-87 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
3/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westminster | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westminster Carroll MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME Robert K. Pritts, Sr., Westminister, MD | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Sinden-Randall</i> | | | | | |



Handwritten text at the bottom left, possibly a signature or date, appearing to read "March 1944".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Sadie E. Green | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 24, 1987 | | | 2b. HOUR A
10:15 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
March 4 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3303 Kenyon Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Candy Dipper | | 12b. KIND OF BUSINESS OR INDUSTRY
Mfg. Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3303 Kenyon Ave. 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas Stefanski | | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST
Cecelia Wozniak | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
218-07-4784 | | 17. INFORMANT ADDRESS
Norbert Green (grandson) 3307 Kenyon Ave. 21206 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Minuter</u>
<u>Minuter</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.
<u>Ventricular arrhythmias, Pulmonary edema</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>86</u> , to <u>3/34</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Patricia Disharoon MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Patricia Disharoon | | | | 22e. ADDRESS
Brehms Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. Nat'l | | 23d. LOCATION CITY OR TOWN COUNTY
Baltimore MD. | | | |
| 24. FUNERAL DIRECTOR NAME
Schmuck Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |

BP

CONFIDENTIAL

[Faint, illegible handwritten text on lined paper]



046732 MAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 3 6 6

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | TINA MARIE GREEN | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS)
LAST BIRTHDAY | | |
| Female | | | Negroid | | | 3-3-86 | | | 1 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| North Carolina | | | U.S.A. | | | | | | Baltimore City | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | Sinai Hospital | | | N/A | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| md. | | | | | | Balto. | | | 2618 Quantico Ave. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| ELGIN GREEN | | | | | | Stephanie Morton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | |
| NO | | | | | | 245-47-5941 | | | | | |
| 17. INFORMANT | | | | | | ADDRESS | | | | | |
| Shirley Morton | | | | | | Rt. 3 Mt. Gilead, N.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Blunt trauma to head</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | |
| | | | | | | | | | | | |
| 19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | | | |
| | | | | | | ? P.M. 3-4-87 | | | | | |
| 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | subject beaten | | | | | |
| 20d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | | | 20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | |
| home | | | | | | 20f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | 2618 Quantico Avenue Baltimore, Maryland | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | DATE SIGNED | | | | | |
| Margarita A. Korell, M.D. | | | | | | 3-5-87 | | | | | |
| 22. ADDRESS | | | | | | 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | | | |
| Removal | | | | | | 3-9-87 | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Roper Grove Cem. | | | | | | Mt. Gilead, N.C. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25. DATE REC'D. BY REGISTRAR | | | | | |
| Calvin B. Scruggs 1412 E. Preston St. | | | | | | MAR 09 1987 | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN LINE 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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046834 MAR 12 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07367
REG. NO.

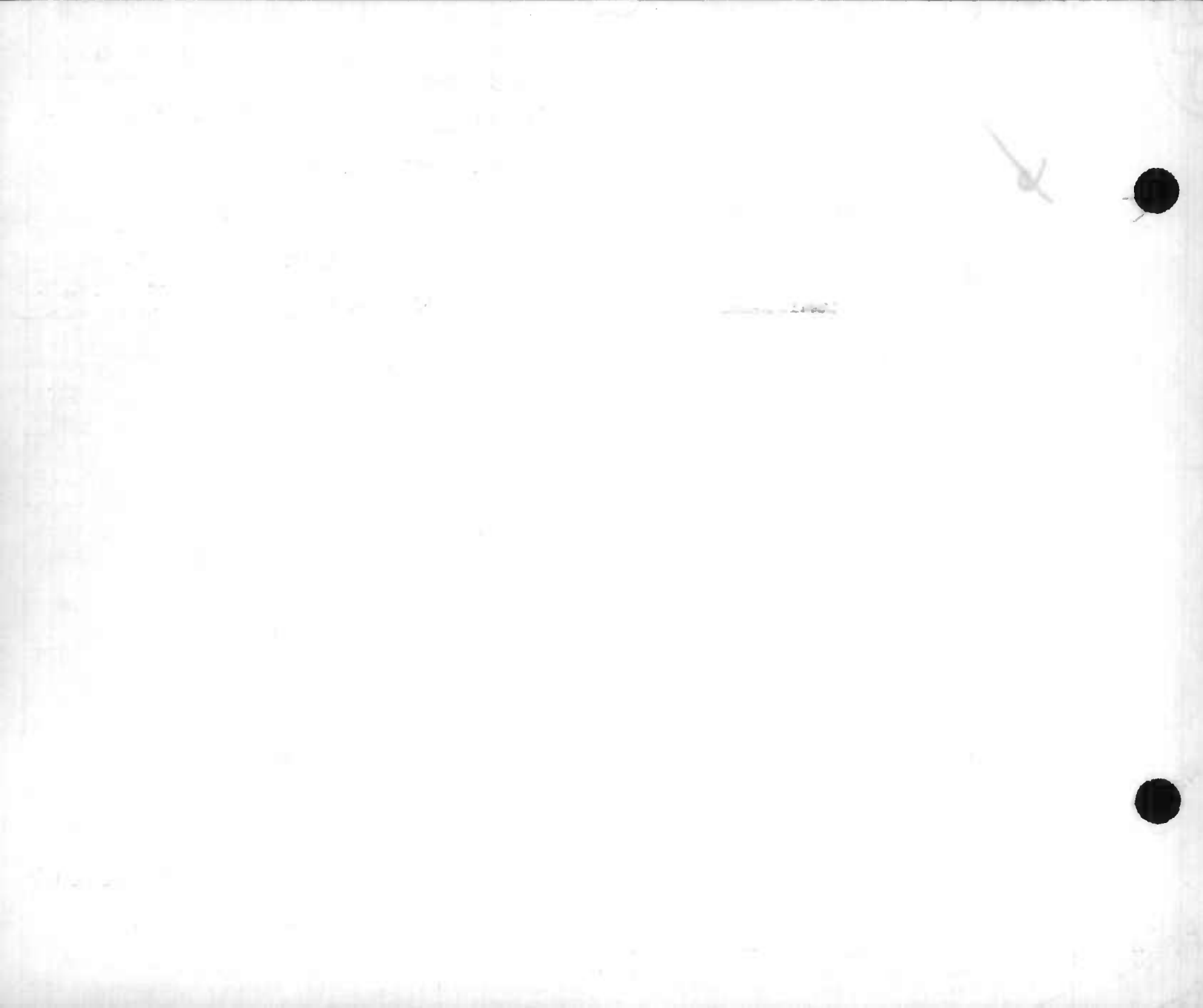
| | | | | | | | | | |
|---|--|---|---|---|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Anna L. Greenberg</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>3 28 87</u> | | 2b. HOUR
<u>7:05 AM</u> | | | | |
| 3. SEX
<u>female</u> | | 4. RACE
<u>caucasian</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>9 22 1896</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>89</u> YRS
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>XXXX PENNA</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Snac Hospital</u> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<u>MD</u> | | | | 13b. COUNTY
<u>Baltimore</u> | | 13c. CITY OR TOWN
<u>Baltimore</u> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>SAMUEL XXXX KENDALL</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>SARAH XXXX BENSTEIN</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
<u>XXXXX NO</u> | | | | 16b. SOCIAL SECURITY NO.
<u>215-28-4501</u> | | 17. INFORMANT
<u>DONALD S. GREENE</u>
<u>6313 WINNER AVE. BALTO., MD 21215</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I (this hospital)) attended the deceased from <u>Feb 23</u> , 19 <u>87</u> , to <u>March 2</u> , 19 <u>87</u> , that (I (we)) last saw the deceased alive on <u>March 2</u> , 19 <u>87</u> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not)) view the body after death. | | | | | | | | 22c. DATE SIGNED
<u>3-2-87</u> | |
| 22b. SIGNATURE
<u>Mary J. Nye</u> MD | | | | 22d. ADDRESS
<u>Snac Hospital, Baltimore, MD 21205</u> | | | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>BURIAL</u> | | 23b. DATE
<u>MAR. 4, 1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>BALTIMORE HEBREW</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>BALTIMORE MARYLAND</u> | | | |
| 24. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS., INC.</u>
<u>6010 REISTERSTOWN RD. BALTO., MD 21215</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 11 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Gordon-Rodner</u> | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires: that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

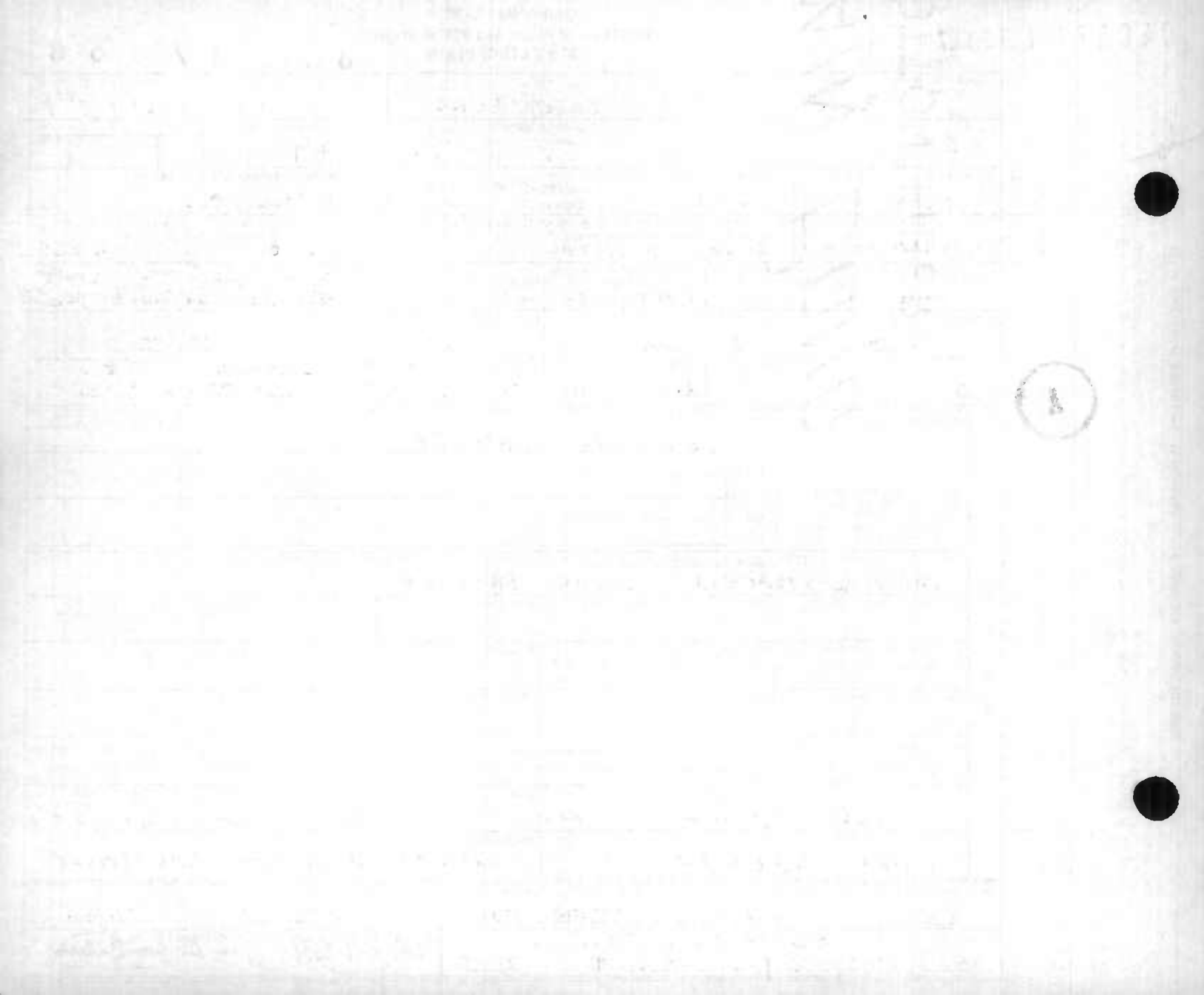
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed page 3 from this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROSE GREENBERG | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 23 87 | | | 2b. HOUR
8 ⁵⁵ P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 11 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
EXEC. SEC. | | 12b. KIND OF BUSINESS OR INDUSTRY
BALTO. HEBREW | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTIMORE | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS & ZIP CODE
4000 N. CHARLES ST. 5 TH FLOOR BALTO. MD 21218 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JACOB GREENBERG | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA SILVERSTEIN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-32-1113 | | 17. INFORMANT
MANNES F. GREENBERG 10 TH FL.
SUN LIFE BLDG. CHARLES CENTER #21201 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>THROMBOCYTOAEMIA - RENAL FAILURE</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Karl Sackman MD | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KARL SACKMAN | | | | | 22e. ADDRESS
SINAI HOSPITAL - BALTIMORE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
MAR. 25, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25. DATE RECEIVED BY REGISTRAR 26. REGISTRAR'S SIGNATURE
MAR 27 1987 Julia Gordon-Randall | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| FIRST MIDDLE LAST
ROSE F. GREENBERG | | | | | MARCH 19, 1987 12:30A M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| FEMALE | | CAUCASIAN | | MARCH 10 1891 | | 96 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | USA | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | LEVINYAVE HEBREW GERIATRIC CENTER HOSPITAL | | | | HOUSEWIFE | | AT HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | | |
| MARYLAND / BALTIMORE | | | | | BALTIMORE | | 7909 LIBERTY ROAD 21207 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| JOSEPH FISHER | | | | | SOPHIE GREENFELD | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| NO | | | | | 215-05-8415D | | MRS. VIVIAN STAPIRO
7909 LIBERTY RD. BALTO., MD 21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) PNEUMONIA | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 3/19 19 87 to 3/19 19 87, that (we) last saw the deceased alive on 3/19 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| ESTREITA O. KUN | | | | | M.D. | | | 3/19/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| | | | | | LEVINYAVE HEBREW GERIATRIC CENTER - HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | | MAR. 20, 1987 | | MOSES MONTEFIORE WOODMOOR HEBREW | | | BALTO., MD | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | MAR 24 1987 Julia T. Davis | | | | |

EXHIBIT 101
JAN 1951

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| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | 101 | 102 | 103 | 104 | 105 | 106 | 107 | 108 | 109 | 110 | 111 | 112 | 113 | 114 | 115 | 116 | 117 | 118 | 119 | 120 | 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 | 129 | 130 | 131 | 132 | 133 | 134 | 135 | 136 | 137 | 138 | 139 | 140 | 141 | 142 | 143 | 144 | 145 | 146 | 147 | 148 | 149 | 150 | 151 | 152 | 153 | 154 | 155 | 156 | 157 | 158 | 159 | 160 | 161 | 162 | 163 | 164 | 165 | 166 | 167 | 168 | 169 | 170 | 171 | 172 | 173 | 174 | 175 | 176 | 177 | 178 | 179 | 180 | 181 | 182 | 183 | 184 | 185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

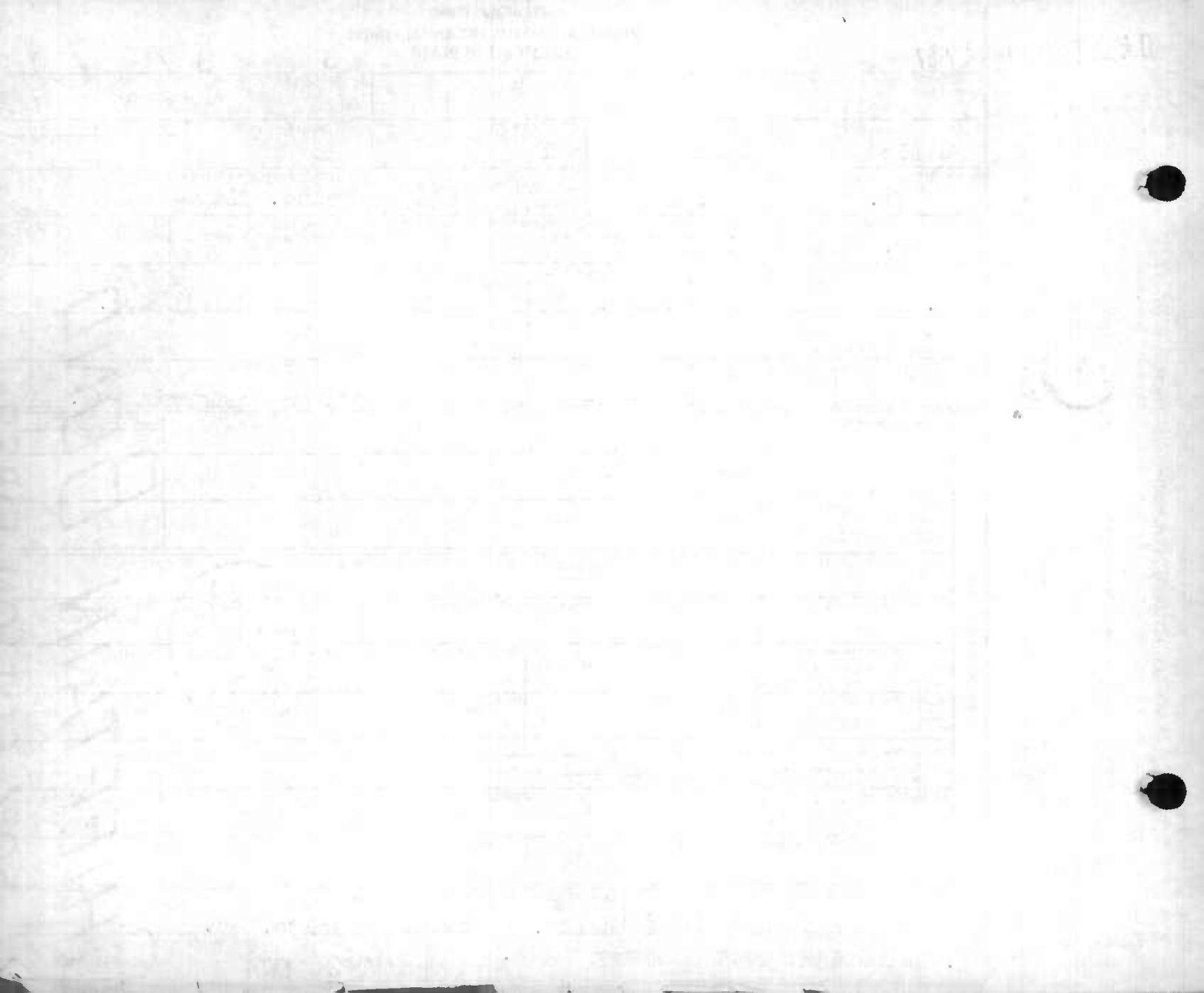
REG. NO. 07370

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Meredith Greene | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 23 87 | | 2b. HOUR
5:19 PM | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 9 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Va. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. City | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Day | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eunice Johnson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | |
| 16b. SOCIAL SECURITY NO.
219-30-6832 | | 17. INFORMANT ADDRESS
James Greene 3426 Mondawmin Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute pulmonary Edema</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Obesity, N.C.V.D., Hypertension</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Barry S. Gold M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Barry S. Gold, M.D. | | 22e. ADDRESS
6804 Park Heights Avenue | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/27/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. National | |
| 23d. LOCATION
CITY OR TOWN
Balto. Md. | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
C. Wainwright | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |
| 2700 Edmondson Ave. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



046422 MAR 7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|--|--|
| Item 8, Film G628 6/11/87 jab
FOR STATE REGISTRAR
12, | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | REG. NO. 07371 |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
DAVID Charles Greenwood | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR
3-3-87 155 4M | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR
10 28 48 | | 6. AGE (IN YEARS LAST BIRTHDAY) 38
YRS. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sergeant Correctional Officer
12b. KIND OF BUSINESS OR INDUSTRY MD Correction | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN
MD Balt Woodlawn | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 21207
4 Retinue Ct. Apt Gr-3 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Willie M. Greenwood | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sadie Bowden | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | 16b. SOCIAL SECURITY NO. 219502041 | 17. INFORMANT ADDRESS
Sadie Greenwood 4900 Cordelia Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Liver Abscesses
DUE TO, OR AS A CONSEQUENCE OF (c) Pancreatic Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (this hospital) attended the deceased from 2/27, 19 87, to 3/3, 19 87, that (we) last saw the deceased alive on 3/3, 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | |
| 22b. SIGNATURE Shanti Ramesh Resident | | 22c. DATE SIGNED 3/3/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHANTI RAMESH |
| 22e. ADDRESS St. Agnes Hospital, 900 Caton Ave, Baltimore, MD 21237 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | |
| 23b. DATE 3/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. |
| 24. FUNERAL DIRECTOR NAME W.C. March F/H 4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR 1 MAR 06 1987 | | |
| 25b. REGISTRAR'S SIGNATURE | | | | |

1985-1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. This permit should be attached to the certificate and the body of the deceased. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07372 | |
|---|--|---|--|--|--|--|--|---|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MAMIE MIDDLE W LAST GRESS | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 03 04 87 | | 2b. HOUR 6:56 AM | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH
MONTH DAY YEAR JUNE 23, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY M.C. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1206 S. CLINTON ST. 21224 | | | |
| 14. FATHER'S NAME FIRST John MIDDLE WALSH LAST | | 15. MOTHER'S MAIDEN NAME FIRST Addie MIDDLE Hutchings LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215 12 8428 | | 17. INFORMANT ADELE LA GRAVE | | ADDRESS SAME AS 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Death
DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-pulmonary arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6:56 | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: U/o bladder cancer | | | | | | | | | | | |
| 19a. DATE OF OPERATION 2/24/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Aortic Aneurysm | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27, 19 87, to 3/4, 19 87, that (I) (we) lost some, the body was there on 3/4, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | | |
| 22b. SIGNATURE Signature Bastidas | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3/4/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Augusto Bastidas | | | | 22e. ADDRESS FSK MC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL | | 23b. DATE 3-7-87 | | 23c. NAME OF CEMETERY OR CREMATORY CRAWFORD CEM. | | 23d. LOCATION CITY OR TOWN COUNTY BALTO. CO MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME HOFFMANN-SKARDIA | | | | ADDRESS 3218 HUDSON ST. | | 25a. DATE REC'D. BY REGISTRAR MAR 05 1987 | | 25b. REGISTRAR'S SIGNATURE J. L. Anderson-Randall | | | |



049275 APR 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

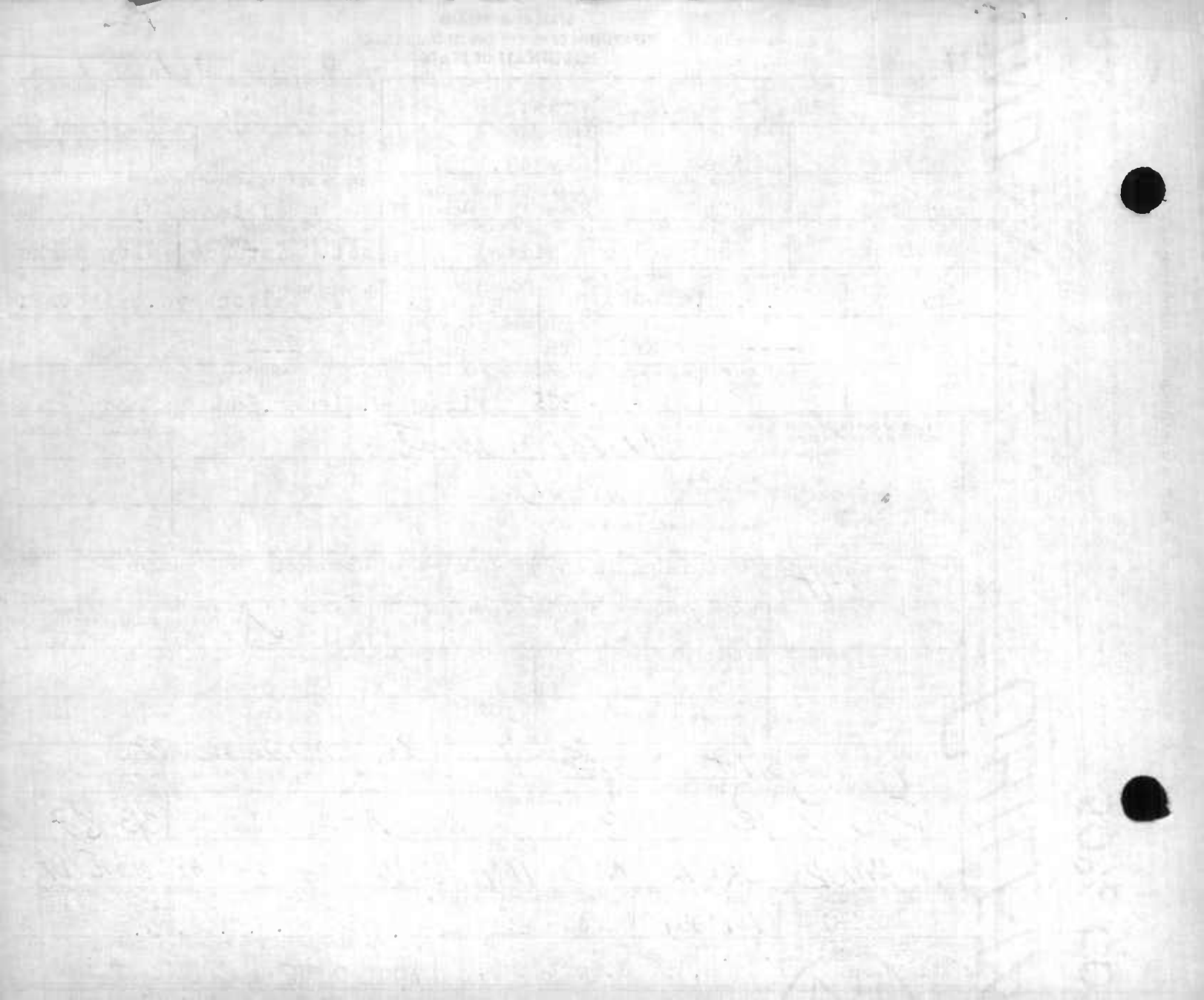
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07374

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Samuel A. Griffith | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 30, 1987 | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 19, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montebello Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY
City Parks | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A.Co. | | 13c. CITY OR TOWN
Brooklyn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Griffith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Adell Thomas | | 13e. STREET ADDRESS
423 Walton Ave. Balto. Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-14-0325 | | 17. INFORMANT
ADDRESS
Shirley E. Siemer, Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ASCVD.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>N/A</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> 19 <u>86</u> to <u>March 30</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/31</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Frank Shea</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/31/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FRANK SHEA | | 22e. ADDRESS
Montebello Hosp. 2201 ARGONNE DR. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/3/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. A.A.Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Home, 130 E. Fort Ave, | | Balto. Md. 21230 | | 25a. DATE REC'D. BY REGISTRAR
APR - 2 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Lia Tindon-Randall</u> | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7375

| | | | | | | | | | | | | |
|--|---------|---|--------|--|----------------|--|--------------------------|-----------------------------------|-----------|----------------------------|----------|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | | 7a. DATE KNOWN OF DEATH | | 7b. DATE OF ESTI-MATED | 7c. MONTH | 7d. DAY | 7e. YEAR | 7f. HOUR |
| DIANE | | GRISSOM | | | | 3-18-87 | | | 3 | 18 | 87 | 9 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | MONTH | DAY | YEAR | 2d. HOUR |
| FEMALE | BLACK | 12 29 1962 | | 24 YRS. | MONTHS | DAYS | 3-18-87 | | 19 | | | 9:12 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MARYLAND | | U. S. A. | | | | Baltimore City | | MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | Franklin Square Hospital | | | | Advertising Printer | | ADVO Systems | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | 13f. CITY OR TOWN | | |
| MARYLAND | | | | BALTIMORE | | | | Maryland 21217 | | 1820 Laurens St. Baltimore | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Daniel J. Grissom | | Marian Edwards | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | |
| Yes | | Reserve Duty | | 213 88-1289 | | Mrs. Marian C. Grissom | | 1708 Ruxton Ave. 21216 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Thermal burns with complications | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | |
| 3:15AM 12/24/86 caught in a housefire | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 1820 LAURENS STREET BALTIMORE, MARYLAND | | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held on behalf of, Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margaret McKeel M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 3-19-87 | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | | | |
| 23b. DATE 3/24/1987 | | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Park | | | | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| Laurel, Maryland | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME NINTER & SONS FUNERAL HOME, INC. ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | |
| MAR 24 1987 | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



047994 MAR 24

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. CASE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THE FORM, PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR
1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REC NO. 07376 | | | |
|---|--|------------------------------|--|---|--|--|--|---|--|--|--|---|--|---|--|---|--|--|--|-------------------------|--|-------------------------|--|
| DECEASED NAME
(NAME OR PRINT) Joy Grolloman | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3-8-1987 | | | | | | | | | | 2b. HOUR 10:50 A | | | |
| 3. SEX
Female | | 4. RACE
polynesian | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 19 1941 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
45 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD 3-8-1987 | | | | | | | | | | 2d. HOUR 10:50 A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hawaii | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4910 Carmine Rd. | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INTER-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
4910 Carmine Avenue | | | | 21201 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lloyd Boone | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eunice Payne | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | (IF YES, GIVE WAR OR DATES)
244-50-0870 | | | | 16b. SOCIAL SECURITY NO.
214-50-0370 | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles P. Kokes | | | | | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 3-13-87 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | | | | | | | ADDRESS
111 Penn St., Baltimore, MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
3-8-87 | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
STATE ANATOMY BOARD BALTIMORE, MARYLAND | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | | | 25b. REGISTRAR'S SIGNATURE
Julia Benson-Randall | | | | | | | | | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

20% COTTON LEEB

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2000

2000



MAR 20 1981

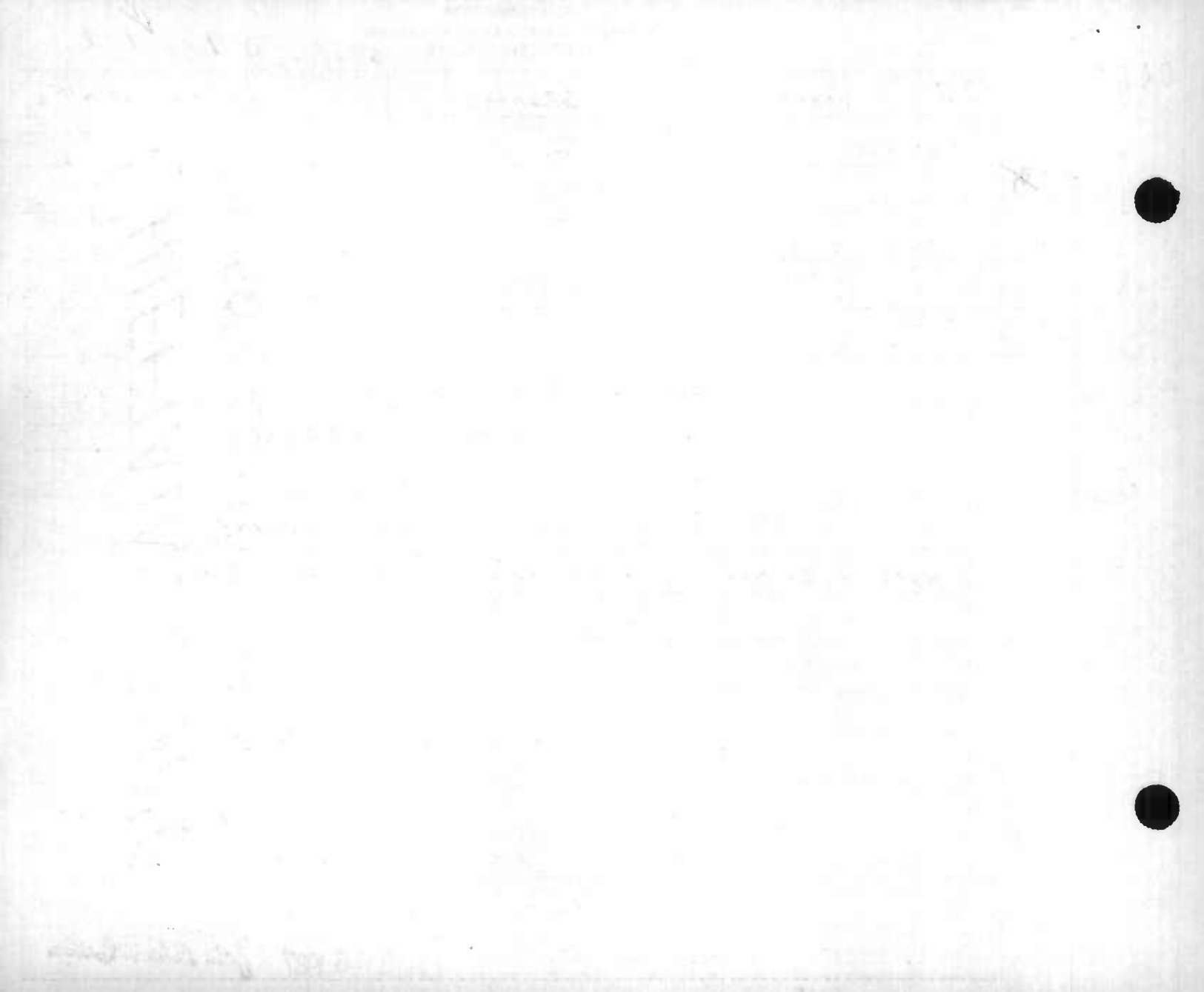


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|-----------------------------------|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(NAME OR PRINT) | | | FIRST MARY MIDDLE B. LAST GROOMS. | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | |
| | | | | | | 03 05 87 | | 2b. HOUR 9 ¹⁵ AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | 1-5-1916 | | 71 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Balto., MD | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore City | | Liberty Hospital | | | | Factory Worker | | Retired | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MD | | | | Balto. City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4003 Eierman Ave. Balto. 21206 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST William Alvather | | | | FIRST MIDDLE LAST Helen Hurley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | 213-28-93 | | 18. Ermindo J. Barsotti | | 10 Wildwood Rd. 21206 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) 912 CARDIO-PULMONARY ARREST | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) POSSIBLE ASPIRATION | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| HYPOTHYROIDISM, CIRRHOSIS LIVER, WITH ASCITES. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> | | AT HOME, STREET, FACTORY, OFFICE, FARM, ETC. | | STREET | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-4-1987 to 3-5-1987, that (I) (we) last saw the deceased alive on 3-5-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| | | | | | | 3.5.87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| SUDHIR. PATEL | | | | LIBERTY MEDICAL CENTRE | | BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| Cremation | | 3-6-87 | | Greenmount Crematory | | Balto. | | MD | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John C. Miller, Inc., 6415 Belair Rd. 21206 | | | | | | MAR 06 1987 | | Julia Gordon-Rodriguez | |

BP



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 87 REG. NO. 07378 | | |
|---|--|---|--|---|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Reuben Grovell | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 6 87 | | | | | 2b. HOUR
10 40 AM | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 15 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Indies | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4104 Penhurst Ave | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Contractor | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4104 Penhurst | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Johnny Grovell | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Lyon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, IF OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
Naomi Jackson 4104 Penhurst Ave | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA PROSTATE
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTASIS (A. PROSTATE)
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/6/85 , 19____, to 2/6/87 , 19____, that (I) (we) last saw the deceased alive on 2/5/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Victor Salaka | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3/6/87 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VICTOR SALAKA MD | | | | | 22e. ADDRESS
15 AQUANECT ROAD Glenview, MD 21611 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3-13-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus mem PK | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Carlton C. Douglass | | | | | ADDRESS
1201 McCallish | | | 25a. DATE REC'D. BY REGISTRAR
MAR 09 1987 | | 25b. REGISTRAR'S SIGNATURE
John J. Anderson | | |



48089 MAR 24 1987

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE Grant GRUBB | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 3 20 87
2b. HOUR
105 P.M. | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 12, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67
YRS. | | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Caddy | | 12b. KIND OF BUSINESS OR INDUSTRY
Golf Course | | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Essex | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Grubb | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
May Gootee | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
ADDRESS
8316 Nunley Dr.
Richard Grubb, Brother Balto., Md. 21234 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia / Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Staph Sepsis, Urine Tract Infection, Large Sacral Decubiti, Pneumonia</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION
_____ | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
_____ | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
AT HOME <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
_____ | | 21f. LOCATION
STREET
_____ | | CITY OR TOWN
_____ | | COUNTY
_____ STATE
_____ | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/13/87</u> , 19 <u>87</u> , to <u>3/20/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/20/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
K. York Smith MSIV / Jeffrey A. Grass MD
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
3/20/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
YORKSMITH / Jeffrey A. GRASS, MD | | | | | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | | 23b. DATE
3/ 23/ 87 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
BALTIMORE CO., MD. STATE
_____ | | | |
| 24. FUNERAL DIRECTOR
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave
ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
_____ | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, and 121, and 122, and 123, and 124, and 125, and 126, and 127, and 128, and 129, and 130, and 131, and 132, and 133, and 134, and 135, and 136, and 137, and 138, and 139, and 140, and 141, and 142, and 143, and 144, and 145, and 146, and 147, and 148, and 149, and 150, and 151, and 152, and 153, and 154, and 155, and 156, and 157, and 158, and 159, and 160, and 161, and 162, and 163, and 164, and 165, and 166, and 167, and 168, and 169, and 170, and 171, and 172, and 173, and 174, and 175, and 176, and 177, and 178, and 179, and 180, and 181, and 182, and 183, and 184, and 185, and 186, and 187, and 188, and 189, and 190, and 191, and 192, and 193, and 194, and 195, and 196, and 197, and 198, and 199, and 200, and 201, and 202, and 203, and 204, and 205, and 206, and 207, and 208, and 209, and 210, and 211, and 212, and 213, and 214, and 215, and 216, and 217, and 218, and 219, and 220, and 221, and 222, and 223, and 224, and 225, and 226, and 227, and 228, and 229, and 230, and 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342, and 343, and 344, and 345, and 346, and 347, and 348, and 349, and 350, and 351, and 352, and 353, and 354, and 355, and 356, and 357, and 358, and 359, and 360, and 361, and 362, and 363, and 364, and 365, and 366, and 367, and 368, and 369, and 370, and 371, and 372, and 373, and 374, and 375, and 376, and 377, and 378, and 379, and 380, and 381, and 382, and 383, and 384, and 385, and 386, and 387, and 388, and 389, and 390, and 391, and 392, and 393, and 394, and 395, and 396, and 397, and 398, and 399, and 400, and 401, and 402, and 403, and 404, and 405, and 406, and 407, and 408, and 409, and 410, and 411, and 412, and 413, and 414, and 415, and 416, and 417, and 418, and 419, and 420, and 421, and 422, and 423, and 424, and 425, and 426, and 427, and 428, and 429, and 430, and 431, and 432, and 433, and 434, and 435, and 436, and 437, and 438, and 439, and 440, and 441, and 442, and 443, and 444, and 445, and 446, and 447, and 448, and 449, and 450, and 451, and 452, and 453, and 454, and 455, and 456, and 457, and 458, and 459, and 460, and 461, and 462, and 463, and 464, and 465, and 466, and 467, and 468, and 469, and 470, and 471, and 472, and 473, and 474, and 475, and 476, and 477, and 478, and 479, and 480, and 481, and 482, and 483, and 484, and 485, and 486, and 487, and 488, and 489, and 490, and 491, and 492, and 493, and 494, and 495, and 496, and 497, and 498, and 499, and 500, and 501, and 502, and 503, and 504, and 505, and 506, and 507, and 508, and 509, and 510, and 511, and 512, and 513, and 514, and 515, and 516, and 517, and 518, and 519, and 520, and 521, and 522, and 523, and 524, and 525, and 526, and 527, and 528, and 529, and 530, and 531, and 532, and 533, and 534, and 535, and 536, and 537, and 538, and 539, and 540, and 541, and 542, and 543, and 544, and 545, and 546, and 547, and 548, and 549, and 550, and 551, and 552, and 553, and 554, and 555, and 556, and 557, and 558, and 559, and 560, and 561, and 562, and 563, and 564, and 565, and 566, and 567, and 568, and 569, and 570, and 571, and 572, and 573, and 574, and 575, and 576, and 577, and 578, and 579, and 580, and 581, and 582, and 583, and 584, and 585, and 586, and 587, and 588, and 589, and 590, and 591, and 592, and 593, and 594, and 595, and 596, and 597, and 598, and 599, and 600, and 601, and 602, and 603, and 604, and 605, and 606, and 607, and 608, and 609, and 610, and 611, and 612, and 613, and 614, and 615, and 616, and 617, and 618, and 619, and 620, and 621, and 622, and 623, and 624, and 625, and 626, and 627, and 628, and 629, and 630, and 631, and 632, and 633, and 634, and 635, and 636, and 637, and 638, and 639, and 640, and 641, and 642, and 643, and 644, and 645, and 646, and 647, and 648, and 649, and 650, and 651, and 652, and 653, and 654, and 655, and 656, and 657, and 658, and 659, and 660, and 661, and 662, and 663, and 664, and 665, and 666, and 667, and 668, and 669, and 670, and 671, and 672, and 673, and 674, and 675, and 676, and 677, and 678, and 679, and 680, and 681, and 682, and 683, and 684, and 685, and 686, and 687, and 688, and 689, and 690, and 691, and 692, and 693, and 694, and 695, and 696, and 697, and 698, and 699, and 700, and 701, and 702, and 703, and 704, and 705, and 706, and 707, and 708, and 709, and 710, and 711, and 712, and 713, and 714, and 715, and 716, and 717, and 718, and 719, and 720, and 721, and 722, and 723, and 724, and 725, and 726, and 727, and 728, and 729, and 730, and 731, and 732, and 733, and 734, and 735, and 736, and 737, and 738, and 739, and 740, and 741, and 742, and 743, and 744, and 745, and 746, and 747, and 748, and 749, and 750, and 751, and 752, and 753, and 754, and 755, and 756, and 757, and 758, and 759, and 760, and 761, and 762, and 763, and 764, and 765, and 766, and 767, and 768, and 769, and 770, and 771, and 772, and 773, and 774, and 775, and 776, and 777, and 778, and 779, and 780, and 781, and 782, and 783, and 784, and 785, and 786, and 787, and 788, and 789, and 790, and 791, and 792, and 793, and 794, and 795, and 796, and 797, and 798, and 799, and 800, and 801, and 802, and 803, and 804, and 805, and 806, and 807, and 808, and 809, and 810, and 811, and 812, and 813, and 814, and 815, and 816, and 817, and 818, and 819, and 820, and 821, and 822, and 823, and 824, and 825, and 826, and 827, and 828, and 829, and 830, and 831, and 832, and 833, and 834, and 835, and 836, and 837, and 838, and 839, and 840, and 841, and 842, and 843, and 844, and 845, and 846, and 847, and 848, and 849, and 850, and 851, and 852, and 853, and 854, and 855, and 856, and 857, and 858, and 859, and 860, and 861, and 862, and 863, and 864, and 865, and 866, and 867, and 868, and 869, and 870, and 871, and 872, and 873, and 874, and 875, and 876, and 877, and 878, and 879, and 880, and 881, and 882, and 883, and 884, and 885, and 886, and 887, and 888, and 889, and 890, and 891, and 892, and 893, and 894, and 895, and 896, and 897, and 898, and 899, and 900, and 901, and 902, and 903, and 904, and 905, and 906, and 907, and 908, and 909, and 910, and 911, and 912, and 913, and 914, and 915, and 916, and 917, and 918, and 919, and 920, and 921, and 922, and 923, and 924, and 925, and 926, and 927, and 928, and 929, and 930, and 931, and 932, and 933, and 934, and 935, and 936, and 937, and 938, and 939, and 940, and 941, and 942, and 943, and 944, and 945, and 946, and 947, and 948, and 949, and 950, and 951, and 952, and 953, and 954, and 955, and 956, and 957, and 958, and 959, and 960, and 961, and 962, and 963, and 964, and 965, and 966, and 967, and 968, and 969, and 970, and 971, and 972, and 973, and 974, and 975, and 976, and 977, and 978, and 979, and 980, and 981, and 982, and 983, and 984, and 985, and 986, and 987, and 988, and 989, and 990, and 991, and 992, and 993, and 994, and 995, and 996, and 997, and 998, and 999, and 1000.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "R", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|---|--|---|--|---|--|---|---------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| Charles Henry Gunkel | | | | | 3 | 27 | 87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | White | MONTH DAY YEAR
4 20 09 | | 77 YRS. | | MONTHS DAYS | | HOURS MIN. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | South Baltimore General Hospital | | | | Gas Attendant | | Cab Company | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. STATE | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | A.A. | Baltimore | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 136 West Meadow Road 21225 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST
John Henry Gunkel | | FIRST MIDDLE LAST
Mamie Schramm | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| No | | 217-01-6604 | | Audrey O. Gunkel | | Same as 13e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>AS + D</u>
(c) <u>year</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>—</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | 3120 18 | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3/19</u> 19 <u>87</u> , to <u>3/20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>E. F. Auer</u> | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>3/29/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. F. Auer</u> | | | | 22e. ADDRESS <u>3001 S. HANOVER ST. 21225</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN COUNTY STATE | | |
| Burial | | 3/31/87 | | Glen Haven Mem Park | | Glen Burnie | | A.A. Md | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| George J. Gonce 4001 Ritchie Hwy Balto Md | | | | APR 1 1987 | | | | | | |

BP

James ...

W

1907

White

Male

Albion, N.Y.

A.A.

Albion

Albion ... with Albion General Hospital ...

Albion ... A.A. ...

Albion

Albion

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

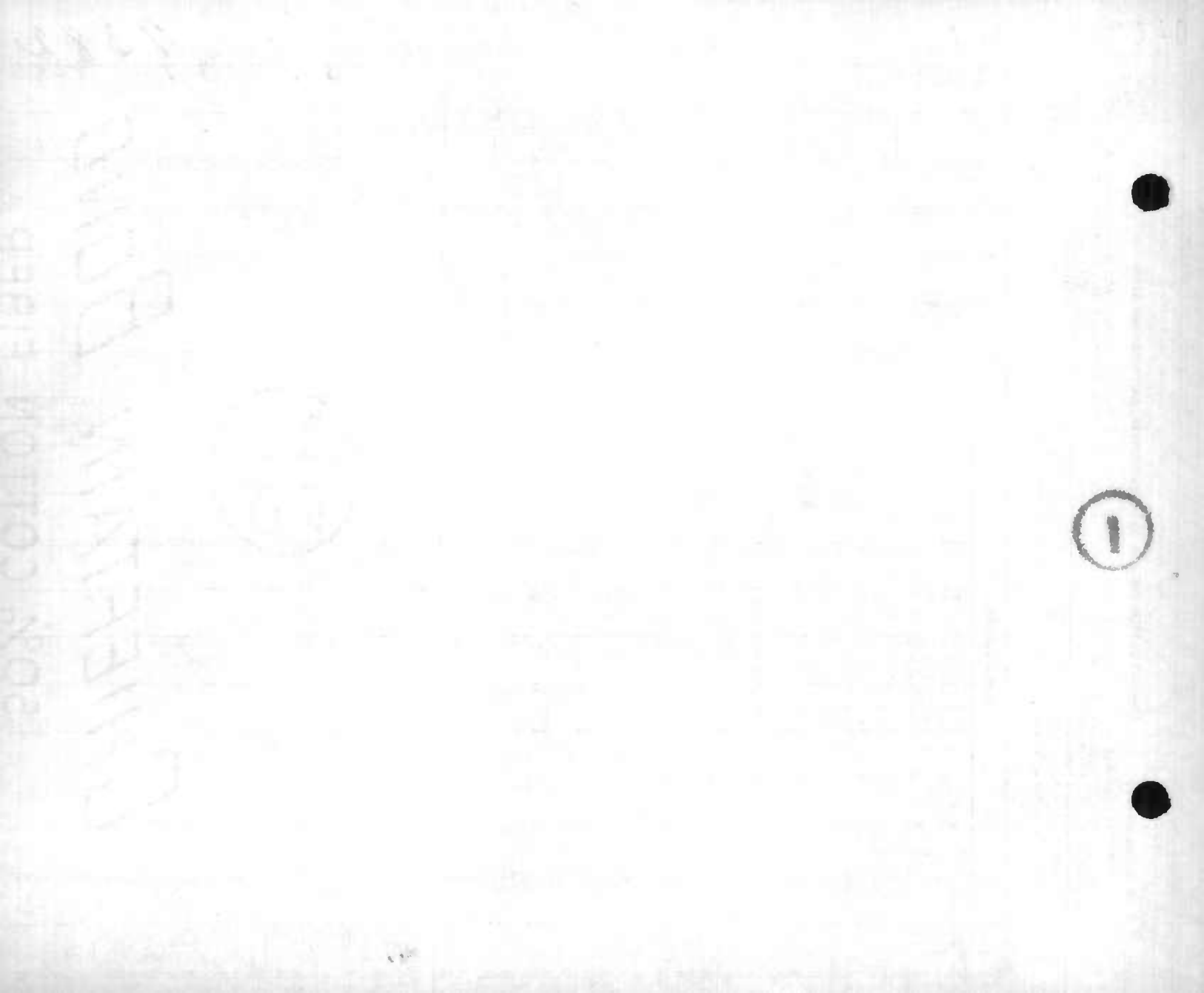
REG. NO.

7382

| | | | | | |
|---|------------------|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Florann Guy | | | 2. DATE KNOWN OF DEATH
MONTH DAY YEAR
3/ 3/ 19 87 | | 2b. HOUR
6:55 P |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 23 1939 | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3/ 3/ 19 87 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4620 Manordene Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | |
| 12b. KIND OF BUSINESS
ELECTRIC | | 13. STREET ADDRESS
Maryland 21229
4620 Manordene Road, Baltimore, | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Henry Preston | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Flemmings | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No. | | 16b. SOCIAL SECURITY NO.
214-38-2514 | | 17. INFORMANT
Address
Ft. Wainwright, Alaska 99703
Sgt. Quentin I. Guy, Sr. 4335-6-9th Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fatty Liver
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural Causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant | | DATE SIGNED
3/4/87 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | ADDRESS
111 Penn St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/11/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Baltimore | | STATE
Maryland | |
| 24. FUNERAL DIRECTOR
NAME
NOTTER & SONS FUNERAL HOME, INC.
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
 | |

DIVISION OF VITAL RECORDS, 2011 PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE RETURNED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THIS CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 2011 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.



046829 MAR 12 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

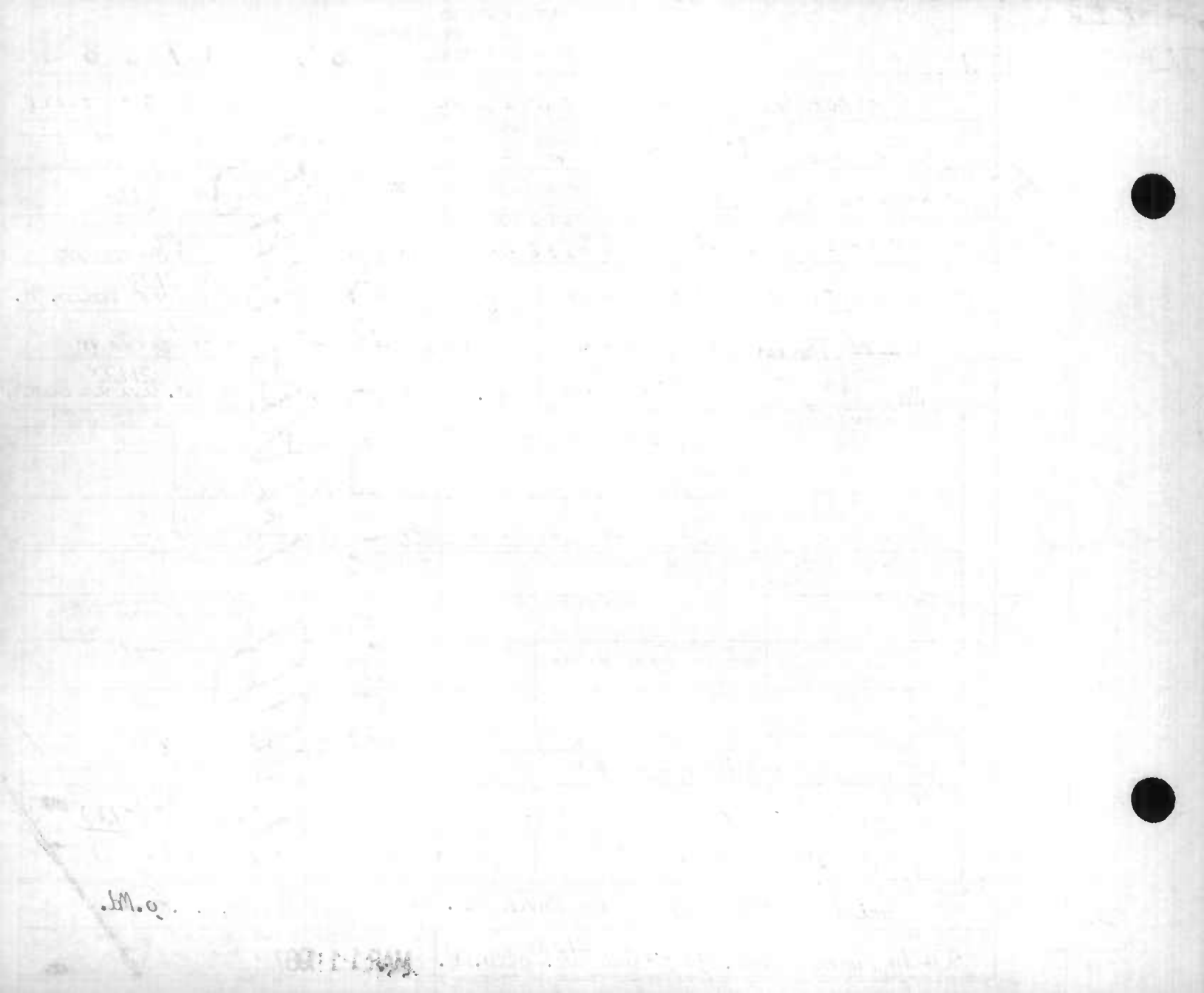
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then attach page 4 to the back of the certificate. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other medic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07383

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARGARET G LAST HADDAWAY | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 9 87 | | 2b. HOUR
7:22 PM | |
| 3 SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8 23 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GEN. HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Homemaker |
| 13a. STATE
Maryland | | | | | |
| 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Thomas HADDAWAY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH - HOLLINGSWORTH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214 616 464 | | 17. INFORMANT
ADDRESS
Mas. Walter Simon, 8573 Bay Rd. Riviera Beach 31122 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) Aortic (11000 mcs. turbid fluid
DUE TO, OR AS A CONSEQUENCE OF
(c) 20 ruptured colonic diverticula
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
ASLVD. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1/87, to 3/9/87, that (I) (we) lost saw the deceased alive on 3/9/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Pratvil Jater | | DEGREE
MD | | 22c. DATE SIGNED
3/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PRATVIL JATER | | 22e. ADDRESS
3007 S. HANOVER ST | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/13/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | |
| 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Glen Burnie, A.A. Co. Md. | | 23e. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | | |
| 24. FUNERAL DIRECTOR
McCully Funeral Home, 130 E. Port Ave. Balto. Md. | | 25a. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | | |



048997 APR 12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please send the completed pages, Pages 1 and 2, should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07384 | |
|--|--|--|------------------------------|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT)
Robert H. Hrenftling | | | 2a. DATE OF DEATH
3 21 87 | | | 2b. HOUR
2:10 PM | | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
7 12 07 | | 6 AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
former employee | | 12b. KIND OF BUSINESS OR INDUSTRY
textile | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Decatur Street 21502 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Gilbert E. Haenftling | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma F. Appel | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
214-07-5813 | | 17 INFORMANT
Mrs. Gladys Poland, Cumberland, MD - sister | | | | ADDRESS | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARDIAC FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>DEHYDRATION</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>N/A</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> 19 <u>87</u> to <u>3/21</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/21/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. A. WINSTON MD | | | | 22e. ADDRESS
2600 LIBERTY HIGGINS AVE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
03-24-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cumberland Allegany MD | | | | | |
| 24 FUNERAL DIRECTOR
NAME
James F. Scarpelli, Cumberland, MD 21502 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |

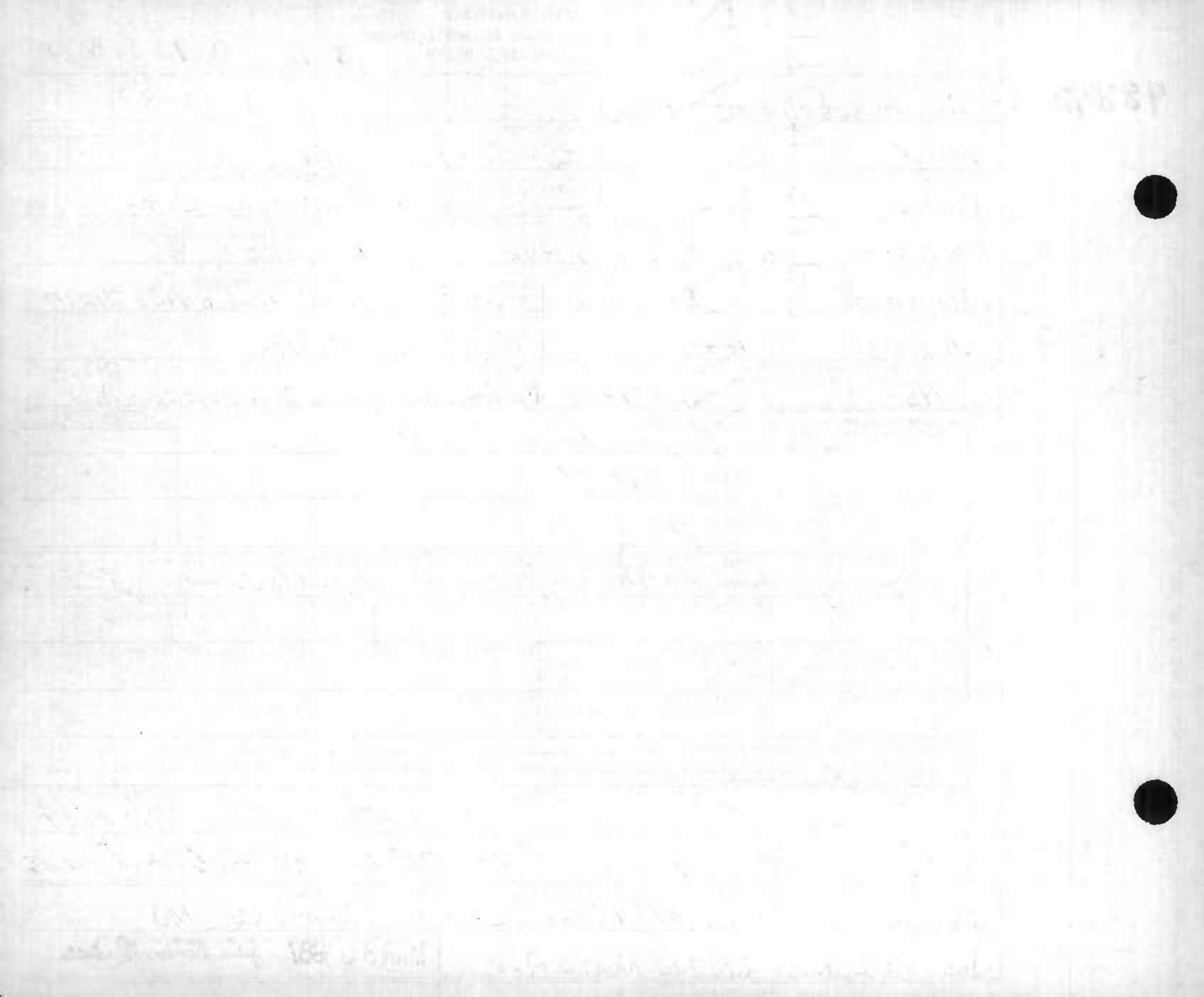
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Main body of handwritten text, appearing to be a letter or a detailed note, covering most of the page.

Handwritten text at the bottom of the page, possibly a signature or a closing.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07385
REG. NO.

| | | | | | |
|--|---|---|---|--|---------------|
| 1. DECEASED NAME
(TYPE OR PRINT) AUGUSTUS HALL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-22-87 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
COL | 5. DATE OF BIRTH
MONTH DAY YEAR
2-21-16 | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2101 WESTWOOD AVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | |
| 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
2101 WESTWOOD AVE 21217 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JULIUS HALL | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELMIRA JONES | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
21212374 | | |
| 17. INFORMANT
ADDRESS
Mrs SARAH WILKERSON 2101 WESTWOOD AVE 21217 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Urinary Tract Disease
DUE TO, OR AS A CONSEQUENCE OF (b) FBP
DUE TO, OR AS A CONSEQUENCE OF (c) ASCUD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypothyroidism, AODM, hypoparathyroidism, hypoadrenalism, Benign | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael A. Hyle | | DEGREE
MD | | 22c. DATE SIGNED
3/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael A. Hyle MD | | 22e. ADDRESS
7527 Belvoir Rd Baltimore 21236 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
3-27-87 | 23c. NAME OF CEMETERY OR CREMATORY
MT Zion Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO Co. MD | | |
| 24. FUNERAL DIRECTOR
NAME
JOSEPH L. RUSS 2222 W. NORTH AVE | | | 25. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | |
| 26. REGISTRAR'S SIGNATURE
Julia Dendron-Rodriguez | | | | | |



047314 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-351-1234.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Lucy S. Hall | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 9, 1987 | | | | | 2b. HOUR
8:53 AM | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Feb. 25, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Davidsonville, Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
312 E. Lake Avenue | | | | 12a. USUAL OCCUPATION
Operator C&P Telephone Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
312 E. Lake Ave. 21212 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George W. Hall | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary M. Boswell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | | 16b. SOCIAL SECURITY NO.
212-05-1291A | | 17. INFORMANT ADDRESS
James Colburn 1608 SW 17th Avenue Ft. Lauderdale, Fla. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the Cecum with</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Extensive metastases</u>
(b) <u>Carcinoma of the Stomach</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 MONTHS
9 years | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 1, 1987, to FEB 9, 1987, that (I) (we) lost saw the deceased alive on JAN 24, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Walter R. Welzant | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
FEB 11, 1987 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Walter R. Welzant, M. D. | | | | | 22e. ADDRESS
6100 York Rd., Baltimore, MD 21212 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Feb. 12 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Marys Annapolis | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Anne Arundel Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME
Robert E. Evans | | | | | ADDRESS
1212 West ST. Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

1940-1941

1940-1941



048537 MAR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07381

| | | | | | | | | |
|--|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SUSIE MAE HALL | | | 2a. DATE OF DEATH
MONTH 3 DAY 22 YEAR 87 | | | 2b. HOUR 11 AM | | |
| 3 SEX
FEMALE | | 4 RACE
BLACK | | 5 DATE OF BIRTH
MONTH 8 DAY 26 YEAR 10 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MASON F. LOR. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DOMESTIC | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST Will MIDDLE Hall LAST Hall | | 15. MOTHER'S MAIDEN NAME
FIRST NEILIE MIDDLE NEILSON LAST NEILSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | |
| 16b. SOCIAL SECURITY NO.
220-30-2680 | | 17. INFORMANT
Ethel Hall ADDRESS
1947 Clifton Ave. 21217 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) CLANGRENE OF (R) FOOT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) CVA (L) C (R) HEMIPLEGIA
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Susan Denman M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
3/22/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUSAN J. DENMAN | | | | 22e. ADDRESS
5000 EASTERN AVENUE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
3/27/87 | | 23c. NAME OF CEMETERY OR CREMATORY
KING PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RANDALLSTOWN MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | | | |



048569 MAR 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07388

| | | | | | | |
|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARGARET I. HAMILTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 23, 1987 | | 2b. HOUR
M
M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
May 15, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | IF UNDER 1 YEAR
MONTHS DAYS
0 0 | IF UNDER 24 HRS
HOURS MIN.
0 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5015 Belair Rd. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Beautician Ret | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13e. STREET ADDRESS / ZIP CODE
5015 Belair Rd. 21206 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert B. Thomas | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margretta | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-01-2453 | | 17. INFORMANT ADDRESS
Mr. Mahlon P. Hamilton Same as #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Possible Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCD.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-20-87 , 19 87 , to 3-23 , 19 87 , that (I) (we) last saw the deceased alive on 3-19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (my) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Donato A. Vargas, Jr. | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donato A. Vargas, Jr., M.D. | | 22e. ADDRESS
4706 Harford Rd. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar 28 1987 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. ADDRESS
Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE
John E. ... |



046350 MAR-9

17 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07389

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) PAULINE T. HAMILTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 / 13 / 87 | | 2b. HOUR
10:00 M |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
3 / 7 / 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
city, Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wood Samanitar Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SOLOMON L. THOMAS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MILDRED FUSCOA | | 13e. STREET ADDRESS / ZIP CODE
5622 Woodmont West Apt A Baltimore 21239 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
223-10-195 | | 17. INFORMANT
DAVID T. HAMILTON ADDRESS
SAME AS 13c | |

| | | |
|--|---|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | DUE TO, OR AS A CONSEQUENCE OF
(b) Spacate non - 9 - wave M.I./CH | |
| | DUE TO, OR AS A CONSEQUENCE OF
(c) Thrombo - embolic CVA | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
S. Kappan, MD | | DEGREE | 22c. DATE SIGNED
3/13/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SAMER ELLAHHAM, MD | | 22e. ADDRESS
56016th Paven Blvd 21239 | |

| | | | |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
CREMATION | 23b. DATE
3-4-87 | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW MEM | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO CO MD |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
THOMAS J. SKADA 2829 HUDSON ST. | | 25a. DATE REC'D BY REGISTRAR
MAR 05 1987 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place is on the carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 REG. NO. 07390 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 3. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2b. HOUR P M | | | |
| RACHEL GRAY HAMM | | | | 3 26 87 5:53 P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | |
| Female | | B | | 9-19-21 | | 65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MD. | |
| Eden N.C. | | USA | | | | City | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | St. Agnes Hospital | | Domestic | | Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | | Balto. | | 13e. STREET ADDRESS / ZIP CODE | |
| | | | | | | 5134 Wolverton 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. SOCIAL SECURITY NO. | | | |
| Charlie Perkins | | Pearlie Tinsley | | 219-16-5858 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 219-16-5858 | | Roland Hamm 5134 Wolverton | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio pulmonary arrest | | | | | | | 24 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) multiple enterocutaneous fistulae | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3/13/87 | | multiple enterocutaneous fistulae | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3, 19 86, to 3/26, 19 87, that (I) (we) last saw the deceased alive on 3/26, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | | | |
| E Bruce MD | | | | 3/26/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| E BRUCE MD | | | | 900 CATON AVE BALTIMORE 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 3-30-87 | | Cedar Hill | | Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25. DATE REGD. AND REGISTRAR'S SIGNATURE | | | |
| James A. Morton & Sons 1701 Laurens St. | | | | MAR 30 1987 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

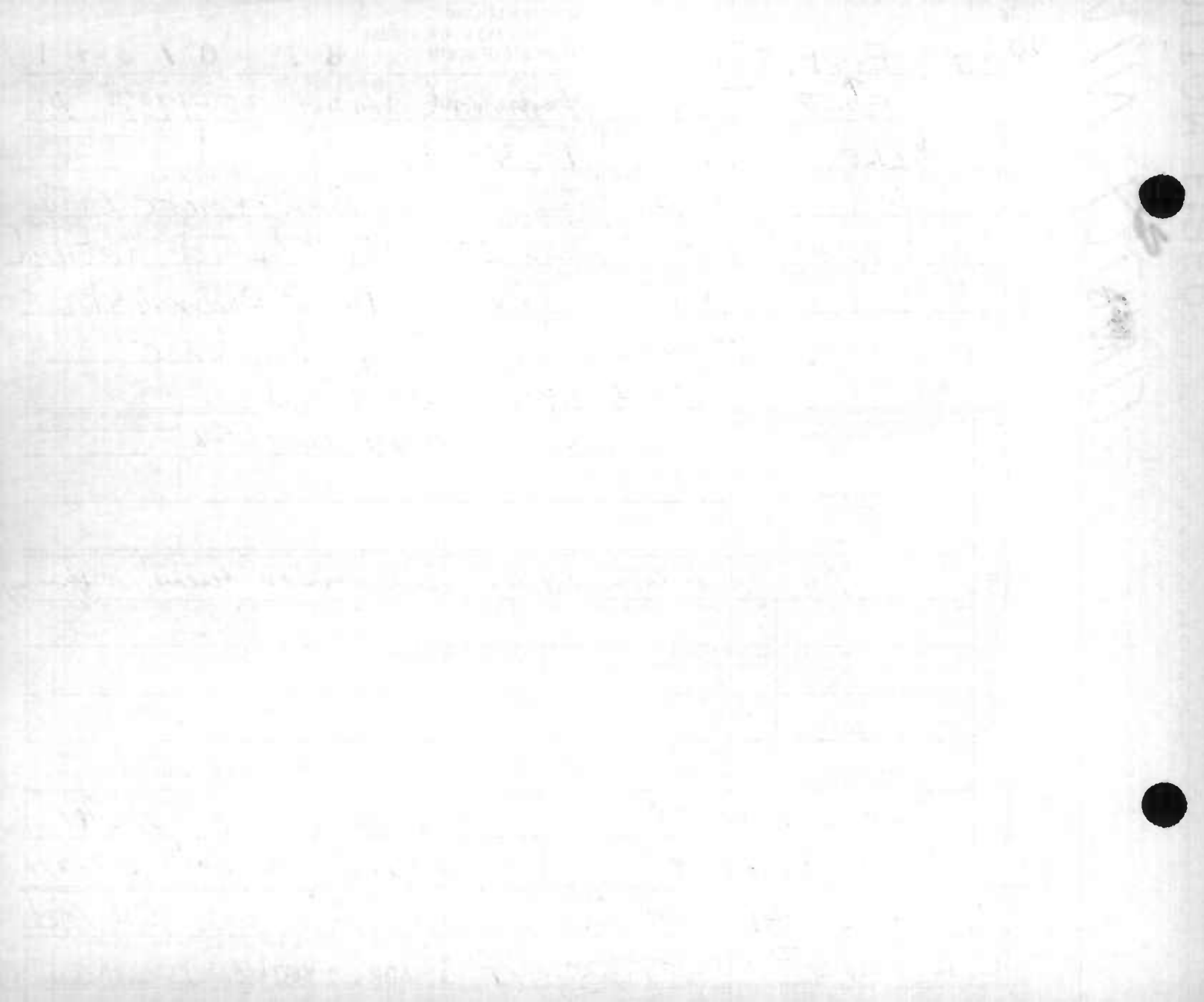
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

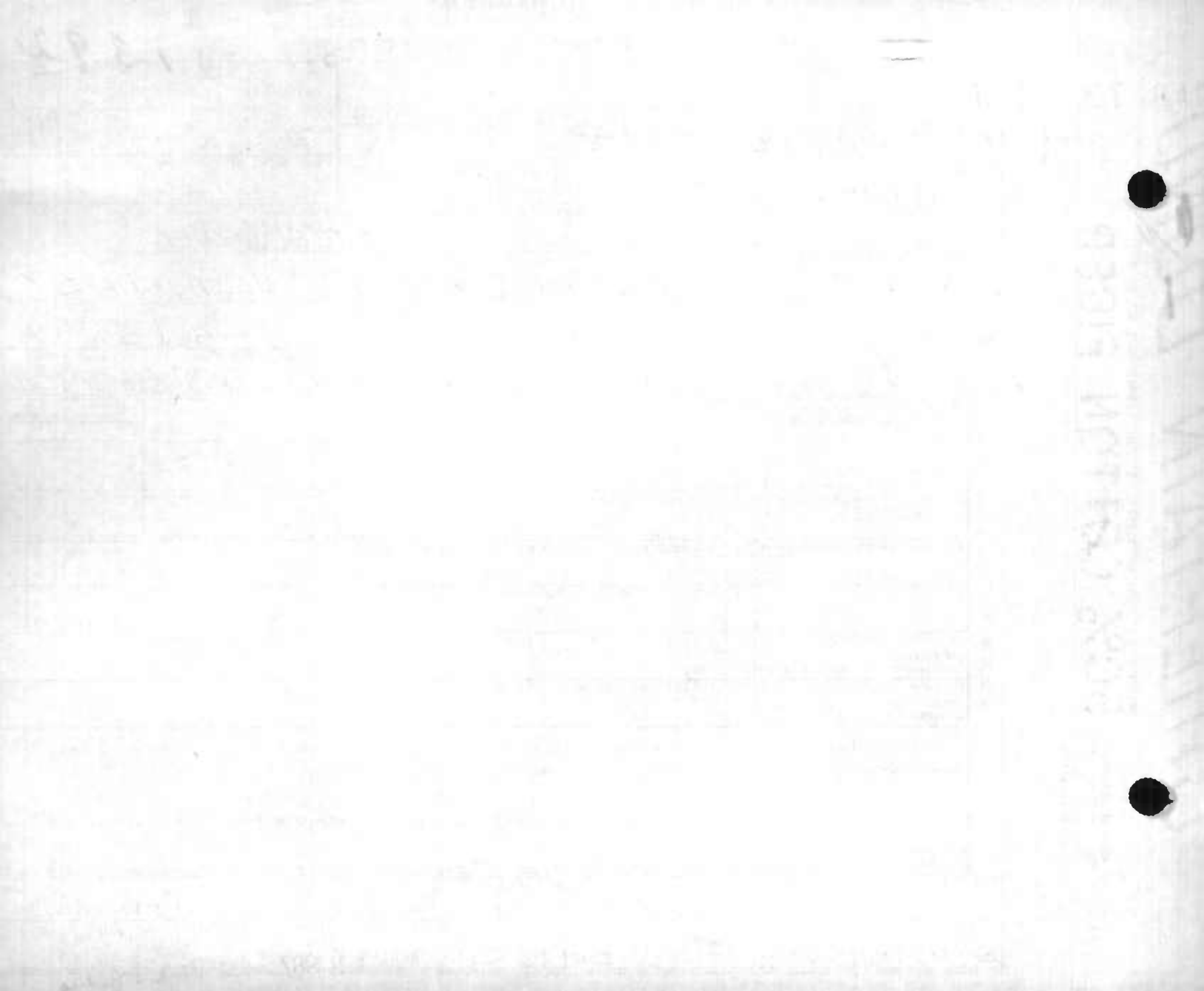
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Everett Thomas Hammond</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>MAR 28-1987</i> | | | 2b. HOUR
<i>P. M.</i> | |
| 3. SEX
<i>MALE</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>1-4-1917</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>70</i> | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Md</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>1-West Conway St.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
<i>Post Office-Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>Md</i> | | 13b. COUNTY
<i>BALT.</i> | | 13c. CITY OR TOWN
<i>West Conway St.</i> | | 13d. STREET ADDRESS / ZIP CODE
<i>21201</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>William Hammond</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Dorothy Butler</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>113-05-5109</i> | | 17. INFORMANT
<i>Phyllis H. Boyd</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Ischemic heart disease - heart attack</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>DM, controlled diabetes, cerebrovascular disease (14 sufficiency)</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Jamer Evans MD</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>3/30/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Jamer Evans MD</i> | | | | 22e. ADDRESS
<i>700 Washington Blvd, Balto, Md 21230</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>Apr 1-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>ANNA POLIS Neck</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>ANNA POLIS A.A. Md.</i> | | | |
| 24. FUNERAL DIRECTOR NAME
<i>C.L. Hicks III</i> | | | | 24b. ADDRESS
<i>ANNA POLIS-Md</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>APR - 1 1987</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Swenson-Randall</i> | |

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXAMINED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

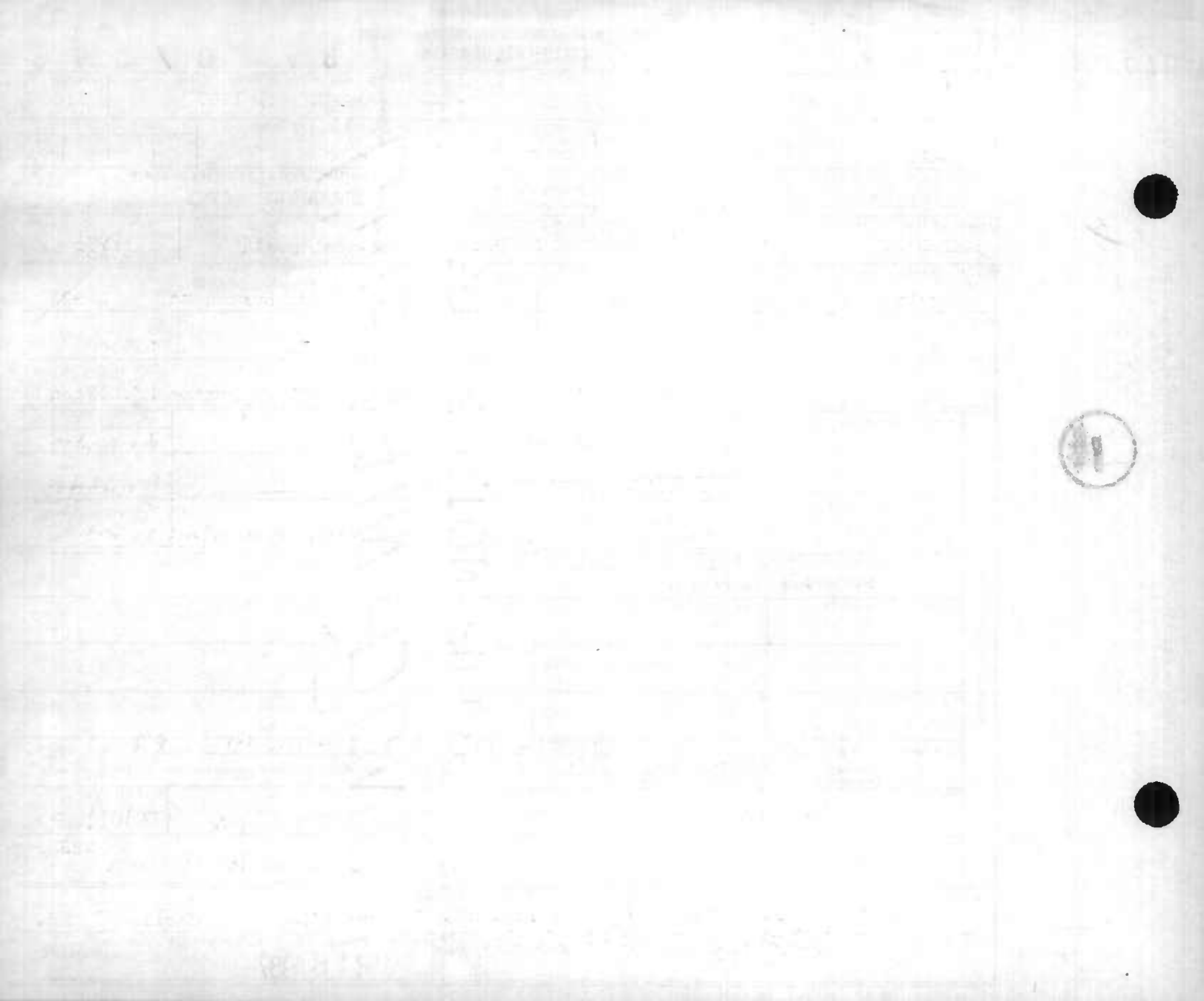
| FOR Med. Ex. / Gbj. DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 07392 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Howard Hammond | | | | | | | | | |
| 2. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-13-16 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
70 YRS. | | 7. DATE KNOWN OF DEATH
ESTIMATED
3/8/1987 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | 7c. DATE PRONOUNCED DEAD
3/8/1987 | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1016 W. Fayette St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
STEELWORKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1016 W. FAYETTE ST. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Hammond | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Jackson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
213-01-0828 | | 17. INFORMANT
ADDRESS
Verna Hammond 2567 Edmondson | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage and airway obstruction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) broncho-aortic fistula
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Arteriosclerotic cardiovascular disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
Charles P. Kokes | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
3/8/87 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | ADDRESS
111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3-12-87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
BROWN/Hompson F.H. | | | | ADDRESS
1913 W. BALTO. ST. | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Pandora | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the pages. Pages 1 and 2 should be buried with the deceased after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
STANLEY W. HAMMOND | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 13, 1987 | | 2b. HOUR P M
7:40 | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
August 14 1952 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
34 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Mental Health Counselor | | 12b. KIND OF BUSINESS OR INDUSTRY
Health Education | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE
Maryland Cecil | | | | | | 13c. CITY OR TOWN
Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Arthur E. Hammond | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary E. Wilson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215 58 3533 | | 17. INFORMANT ADDRESS
Mary B. Hammond, 1002 Warburton Rd. Elkton | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Immune deficiency resulting from Retroviral Infection</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 minutes</u>
<u>8 minutes</u>
<u>8 months</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>Kaposi's Sarcoma</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> , 19 <u>87</u> , to <u>March 14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>C. Lowell</u> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
3/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>C. Lowell</u> | | | | 22e. ADDRESS
601 N. Broadway Balto, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Trinity A.U.M.P. Ch Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Zion Cecil Md. | | | |
| 24. FUNERAL DIRECTOR
NICKS HOME FOR FUNERALS | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card tags 1 and 2 and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

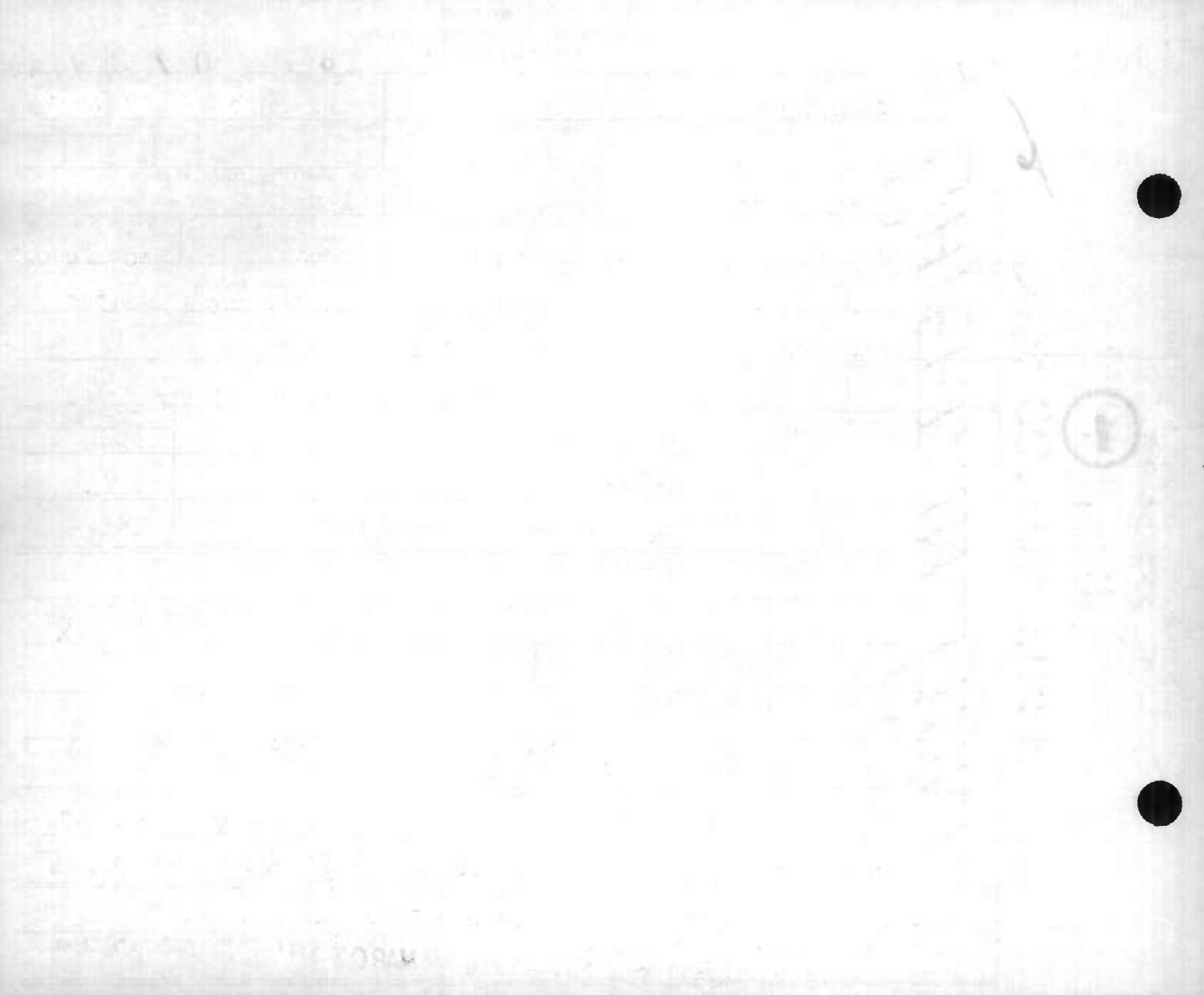
FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07394

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHRISTOPHER T. HANSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 2, 1987 | | 2b. HOUR
12:54 PM |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
9/17/71 | 6. AGE (IN YEARS LAST BIRTHDAY)
15 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | 12b. KIND OF BUSINESS OR INDUSTRY
High School | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
Md. Balto | | | 13b. CITY OR TOWN
Balto. | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dennis Hanson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Phyllis Butterfield | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO - | | 16b. SOCIAL SECURITY NO.
216-84-7730 | 17. INFORMANT
ADDRESS
Dennis Hanson (father) same add. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bone marrow TRANSPLANT</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 hrs</u>
<u>9d</u>
<u>31d</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/31</u> 19 <u>87</u> , to <u>3/2</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>3/2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>D. Garner, MD</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GARNER | | 22e. ADDRESS
601 N. Wolfe St, Balt. Md 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/5/87 | 23c. NAME OF CEMETERY OR CREMATORY
St. Joseph's Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
9705 Belair Road, Balto., Md. 21236 | | | 25a. DATE REC'D. BY REGISTRAR
MAR 03 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Richard R. Rader</u> |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN M. HANZELMAN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 / 23 / 87 | | | 2b. HOUR
A M
10:20 A | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 29, 1911 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY
CREDIT UNION | |
| 13a. STATE
MARYLAND | | | | | 13b. CITY OR TOWN
CATONSVILLE | | 13c. STREET ADDRESS / ZIP CODE
115 NEWBURG AVENUE 21228 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FREDERICK HANZELMAN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JENNIE L. OSWALD | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
WW II 161-05-0260 | | 17. INFORMANT
ADDRESS
LOUISE A. RICKETTS 1531 S. ROLLING ROAD RELAY, MD. 21227 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3/23/87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/23/87 to 3/23/87 , that (I) (we) lost saw the deceased alive on 3/23/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Chitra Chandra MBBS DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
3/23/87 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A-K. CHOPRA | | | | | 22e. ADDRESS
900 S. CATON AVE BALTIMORE MD 21229 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
3/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CATONSVILLE MARYLAND | | |
| 24. FUNERAL DIRECTOR
LEX M. & RUSSELL C. WITZKE ADDRESS
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 REG. NO. 07396 | |
|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR | | |
| 1 DECEASED NAME (TYPE OR PRINT) ELUISE CASE HARDING | | | 3 11 87 0815a _M | | |
| 3. SEX female F | 4 RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 1 3 27 | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teller | 12b. KIND OF BUSINESS OR INDUSTRY Bank | | |
| 13a. STATE Maryland | 13b. CITY OR TOWN Baltimore | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE 5741 Mineral Avenue 21227 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ralph W. Smith, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary T. Meyers | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 214-26-8189 | | 17. INFORMANT ADDRESS Theodore A. Harding 5741 Mineral Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular / Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) metastatic carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF (c) hypercalcemia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mos
2 mos |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION 2-24-87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated peptic ulcer of pylorus | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) this hospital attended the deceased from 2-24-87, 19 87, to 3-11, 19 87, that (b) I saw the deceased alive on 3-11, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE James Dewey Dunn | | DEGREE MD | | 22c. DATE SIGNED 3-11-87 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) James Dewey Dunn | | 22d. ADDRESS 900 Caton Avenue Balt. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 03/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | |
| 23d. LOCATION CITY OR TOWN County State Dorsey Howard Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Ambrose | | ADDRESS 1328 Sulphur Spring Road | | 25a. DATE REC'D BY REGISTRAR MAR 12 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

200

WILEY & SONS

20% COTTON FIBRE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--|
| FOR
1 - STATE REGISTRAR | | | | | REG. NO. 07397 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Louise Hardy | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 25 87
2b. HOUR
14 M | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
12 22 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltio. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lafayette Square Nursing | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY
PVT. FAMILY | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3408 WOODBROOK AVE. 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WILLIAM HARDY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LUCINDA UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)
NO. | | 16b. SOCIAL SECURITY NO.
211-16-1949A | | 17. INFORMANT MR. BALTIMORE, MD. 21217
JOHN JOHNSON 3408 WOODBROOK AVENUE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) Right BASAL GANGLIA INFARCT
DUE TO, OR AS A CONSEQUENCE OF (c) HASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour
1 month
years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) the hospital attended the deceased from 3-18, 1987, to 3-25, 1987, that (I) last saw the deceased alive on 3-24, 1987, and that in (my) an opinion death occurred on the date and hour and from the causes stated above, (I) do (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Richard Tyson, MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
03/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD TYSON, MD. | | | | 22e. ADDRESS
936 W. NORTH Ave.
BALTO, MD 21217 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/30/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL HOME (NAME)
MUTTER + SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PKWY. BALTO, MD. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Rendell | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon duplicate pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible handwriting throughout the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

17. FOR
STATE
REGISTRAR

8 REG. NO. 07398

| | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
2. Royall T. Hardy Nardy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-21-87 | | | 2b. HOUR
1004 AM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 12 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Driver-Salesman Brewery | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
601 N. Bouldin St. 21205 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Rufus E. Hardy | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Ayers | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
216-05-4236 | | 17. INFORMANT
ADDRESS
Sarah Hardy, Same as 13e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Decubitus Ulcer</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>7 days</u>
<u>1 year</u> | | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Cerebral Vascular Accident, Ischemic Heart Disease</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>15 March</u> , 19 <u>87</u> , to <u>21 March</u> , 19 <u>87</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>21 March</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>David A. Jung</u> | | | | | DEGREE
MD | | 22c. DATE SIGNED
21 March 1987 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>David A. Jung</u> | | | | | 22e. ADDRESS
<u>Liberty Medical Center</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
3-25-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | |

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THE UNIVERSITY OF MICHIGAN

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047993 MAR 24 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH07399
RECEIVED ANATOMY BOARD OF MARYLAND

| | | | | |
|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
LEWIS HARGETT | | | 2a. DATE OF DEATH
BALTIMORE, MARYLAND
3/8/87
3:30 AM | |
| 3. SEX
MALE | 4. RACE
CAUC. | 5. DATE OF BIRTH
MONTH DAY YEAR
2/23/04 | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S.A. | 7b. CITIZEN OF WHAT COUNTRY?
AMERICA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KEY CIRCLE HOSPICE | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TRUCK DRIVER | 12b. KIND OF BUSINESS OR INDUSTRY
TRUCKS | |
| 13a. STATE
MD. | | 13b. COUNTY
FREDRICK | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LUTHER HARDY HARGETT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA NUN SHOWER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES ??? | | 16b. SOCIAL SECURITY NO.
213-14 8719A | 17. INFORMANT
ADDRESS
MR. PETER LEMBESIS-1325 W. LOMBARD STREET | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardio pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) cardiac arrhythmia 2nd of
DUE TO, OR AS A CONSEQUENCE OF (c) left A.K. Amputation
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-19-86 to 3-8-87 , that (I) (we) last saw the deceased alive on 3-8-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
G. Shah | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/10/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. G. SHAH | | 22e. ADDRESS
2105 N. Charles St. BALTIMORE | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | 23b. DATE
3-08-87 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
STATE ANATOMY BOARD BALTIMORE, MD | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rodwell |

BP

AMERICAN

COLUMBIAN

MAR 20 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07400

| | | | | | | | | | | |
|---|--|--|--|---|------------------------------------|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles Harkins | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 13 1987 | | | 2b. HOUR
11:21 PM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-4-13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 6. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
501 W. Franklin St. 21201 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Harkins | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unkn. | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
034-01-7952 | | 17. INFORMANT
ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Chronic Lung Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Emphysema</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Cerebral Ischemic Failure</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 11</u> , 19 <u>86</u> , to <u>3/10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert B. Keough</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/13/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Robert B. Keough</u> | | | | | | 22e. ADDRESS
<u>8620 Lehigh Place N.E.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
3-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | | | | | | | | |

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RECEIVED
JAN 10 1965
U.S. AIR FORCE

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TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report with several paragraphs.]



046712 MAR 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

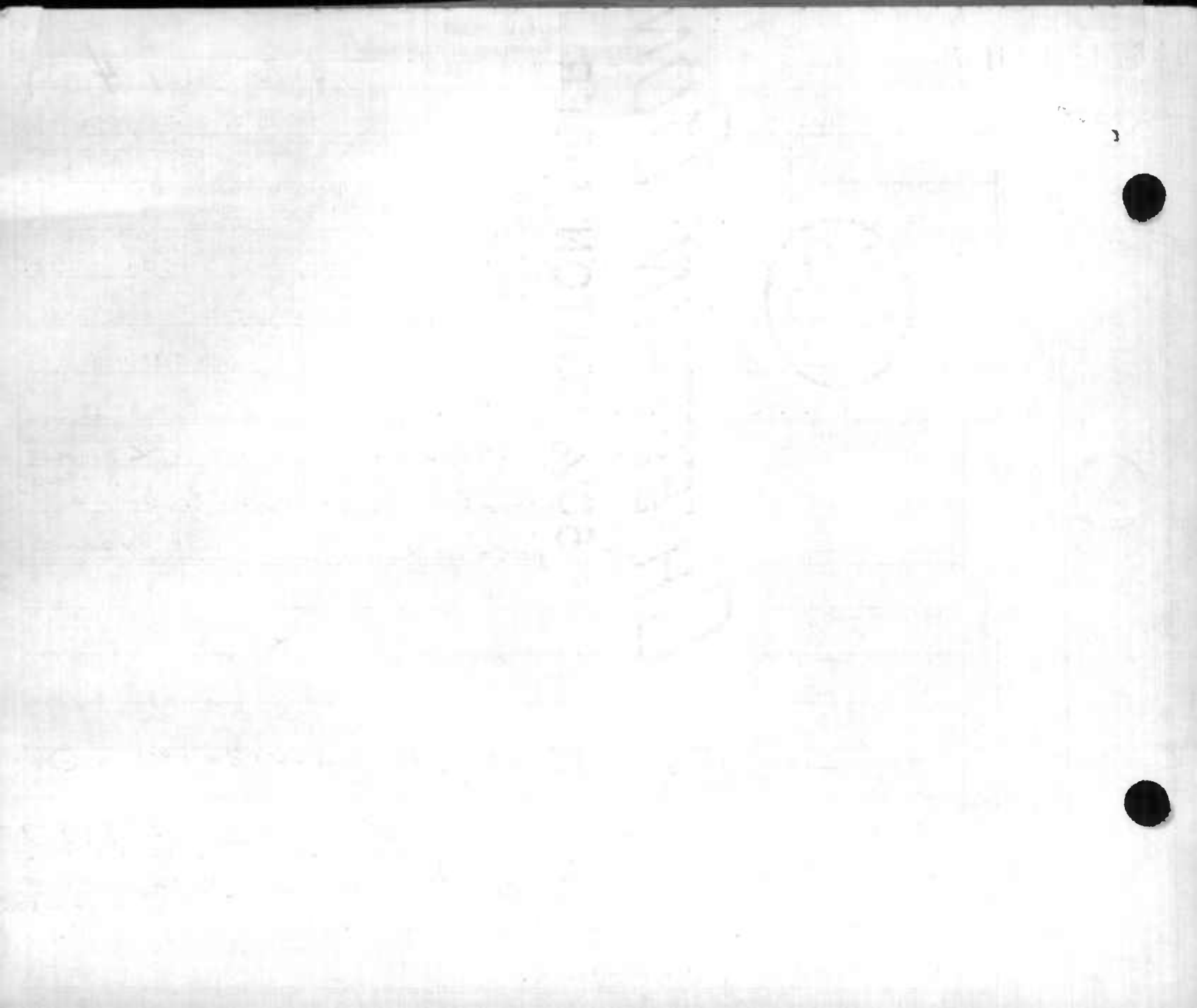
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers, pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|-----------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Francis Xavier HARRINGTON | | | | | 2. DATE OF DEATH MONTH DAY YEAR
March 7, 1987 | | 2b. HOUR
2:45 P.M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 3, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
70 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Newport R.I. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Balto Gen'l Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Calvert Dist. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Linthicum | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
113 North Orchard Road 21090 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Samuel Harrington | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Frances Sullivan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
W.W. II 039.03.3247 | | 17. INFORMANT ADDRESS
Adele D. Harrington (Wife) Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>< 1 hour</u>
<u>(years)</u>
<u>years.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 27</u> 19 <u>75</u> to <u>Feb 18</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Feb 18</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Peter O. Kwitewich, M.D.</u> | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/9/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER O. KWITIEWICH, SR. | | 22e. ADDRESS
600 N. Wolfe St. Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar. 10, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Elkridge Howard Md. | | 23e. DATE REC'D. BY REGISTRAR
MAR 10 1987 | |
| 24. FUNERAL DIRECTOR NAME
Singleton Funeral Home, Glen Burnie, Md. | | 25. REGISTRAR'S SIGNATURE | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial-transit removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST JOHN
HARRIS | | MIDDLE ALBERT
A. | | LAST HARRIS, SR.
John | | 2a. DATE OF DEATH
MONTH 03 YEAR 1987 2b. HOUR 10:25AM | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH 04 DAY 21 YEAR 1912 | | 6. AGE
IN YEARS (LAST BIRTHDAY) 74 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven V.A. Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Track Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 13a. STATE
Maryland | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Abingdon | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3217 Abingdon Road 21009 | |
| 14. FATHER'S NAME
FIRST John MIDDLE Clayton LAST Harris | | | | 15. MOTHER'S MAIDEN NAME
FIRST Lillie MIDDLE Washington LAST Washington | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
Annie L. Harris, 3217 Abingdon Rd., Abingdon, Md. | | 18. DATE OF OPERATION
3/18/87 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic Shock
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Gastric Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c) Severe Atherosclerotic Vascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
10 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
3/18/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bowel Obstruction | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/19 , 19 87 , to 3/20 , 19 87 , that (I) (we) lost the deceased alive on 3/20 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Wm C Dooley MD | | DEGREE
MD | | | | 22c. DATE SIGNED
3/20/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wm C Dooley MD | | 22e. ADDRESS
Loch Raven V.A. Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar. 24, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
John Wesley U.M. Cemetery, Abingdon Harford Md. | | 23d. LOCATION
Abingdon Harford Md. | | | |
| 24. FUNERAL DIRECTOR
Howard K. McComas III, Abingdon, Md. 21009 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
Edith... | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

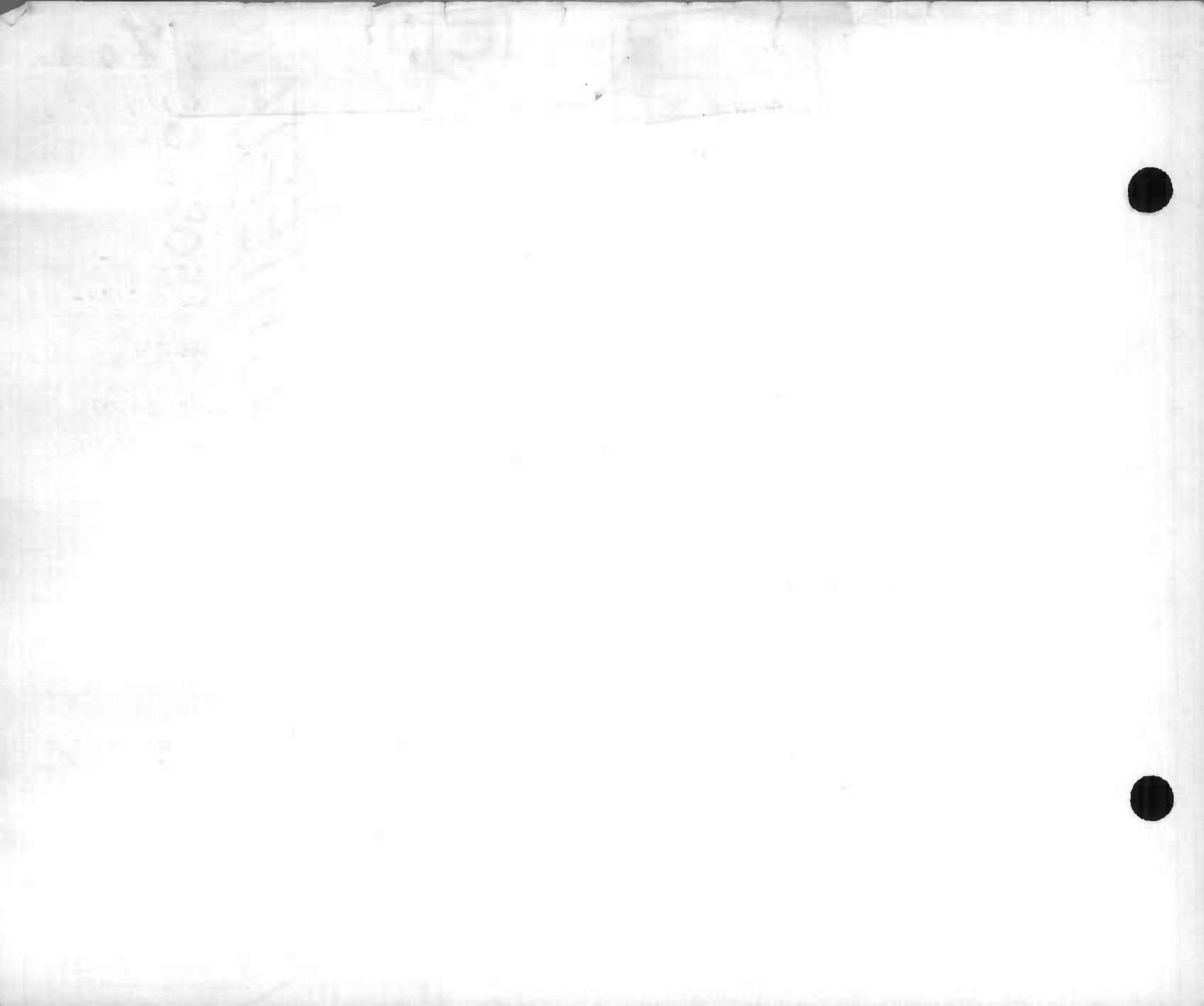
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages in the order indicated on the back of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|-----------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. 07403 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. 07403 | | | |
| ELIZABETH B. HARRU | | 03 06 1987 | | 630 A M | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Female | Black | MONTH 12 DAY 28 YEAR 1923 | 63 YRS. | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| Baltimore | USA | | Baltimore City | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | SINN HOSPITAL OF MD | | Social Security | | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2313 ELEANOR AVE 21216 | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FLOYD DAVIS | | BESSIE PETERS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 213 20 4266 | | Charles Harris Jr. 5233 Linden Heights | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE myeloma hypocalcemia anemia
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/85 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) the hospital attended the deceased from 12/28, 19 82, to 3/6, 19 87, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 3/5, 19 87, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, check this box.) | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3/6/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| ALDINE H. LESSON MD | | 3610 FORDS LANE MD 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 3/11/87 | | Garrison Forest Cem. | | Owings Mills Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| W.C. March F/H West 4300 Wabash Ave. | | | | MAR 09 1987 | | Julia Tindem-Rudman | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Linwood E Harris | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 3/21/87 | | 2b. HOUR
3:51 M. | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR 6 3 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto., City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bn Secours Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joe Willie Harris | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Lindsay | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
239-12-5159 | | 17. INFORMANT
ADDRESS
Pt's chart | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the lungs
DUE TO, OR AS A CONSEQUENCE OF (c) 2 mos. | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 80 to March 19 87 , that (I) (was)
saw the deceased alive on 30 March 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Joshua R. Mitchell M.D. | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
3/21/87 | | 22d. ADDRESS
2202 Garrison Blvd. Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
LEROY O. DYETT | | | | | ADDRESS
4600 Liberty Heights | | 25a. DATE REC'D. BY REGISTAR
MAR 26 1987 | | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | | |

BP

401-10

RECEIVED BY THE
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.



COTTON BUREAU

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

1919

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07405

| | | | | | | | | | |
|---|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Fannie Harris | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 5 87 | | | 2b. HOUR
1730 M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
UNOBTAINABLE | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
— | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
— | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7c. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
CARROLL | | 13c. CITY OR TOWN
SYKESVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SIMON HARRIS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
YETTA BULLARK | | | 13e. STREET ADDRESS / ZIP CODE
TAWES N.H. - SPRINGFIELD STATE HOSP. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-48-0200 | | 17. INFORMANT
SAMUEL HARRIS | | | ADDRESS
APT. 104 3900 FORDS LA. BALTO., MD 21215 | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) UTI
DUE TO, OR AS A CONSEQUENCE OF (c) — | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Fecal impaction w/ ileus, Hyperosmolar, nonketotic hyperglycemia, Resp. failure, Renal | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 4 , 19 87 , to March 5 , 19 87 , that (I) (we) last saw the deceased alive on March 5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Gonzalo J. Urbans | | | | 22c. DATE SIGNED
3/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
900 S Caton Avenue Balto, Md 21229 | |

| | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MAR. 8, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
AITZ CHAIM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | |

1944

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with attached

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4

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1944 - 1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

07406

| FOR
STATE
REGISTRAR | | REG. NO. * | |
|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JULIUS HARRIS | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 6 1987 | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH MONTH DAY YEAR
11 20 37 | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHN L. DEATON | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNK | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JULIUS LEBORD HARRIS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
RUTH VIRGINIA HARRIS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
226-48-2243 | |
| 17. INFORMANT ADDRESS
BENJAMIN Harris 261 S. Dallas St. 21231 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Squamous cell carcinoma of the tongue.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 4 19 87 , to Feb 6 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on March 6 19 87 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | 22b. SIGNATURE DEGREE
George Taler M.D. | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
George Taler, M.D. | | 22d. ADDRESS
600 Light St. Balt. Md. 21230 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/12/87 | |
| 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
LANSWOWNE MD | |
| 24. FUNERAL DIRECTOR NAME
March Funeral Home 1101 E North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | |
| | | 25b. REGISTRAR'S SIGNATURE
Julia Deaton-Rodner | |

MEDICAL CERTIFICATION

0490



1

1



MAR 20 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be ascertained within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued, the funeral director, paid by the family, should be detached for use as the burial-transit permit. Then please remove the permit from the certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07407 | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
KENNETH HARRIS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 7, 1987 | | 2b. HOUR
9:33P
M | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
7 18 54 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
32 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
KENTUCKY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTO. | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1924 N. AISQUITH ST. 21202 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JACK NORRIS HARRIS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
VERA MAY CAMPBELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
220648189 | | 17. INFORMANT ADDRESS
SHERIAN ANDERSON 815 GILRULIN CT. APT 10 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alcoholism</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 mins.
48 hrs.
Years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anemia, Thrombocytopenia, Coagulopathy</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>87</u> , to <u>3/7</u> , 19 <u>87</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>3/7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Steven D. Datorre</u> | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/7/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven D. Datorre | | | | 22e. ADDRESS
JHH, 600 N. Wolfe
Balt. Md. 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. ZION CEMETERY | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE
LANSOWNE MD | | | |
| 24. FUNERAL DIRECTOR NAME
MARCH FUNERAL HOME | | | | ADDRESS
1101 E. NORTH AVE | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia D. Anderson</u> | |



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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

046777 1A FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8.7 07 08 REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) MELCHOUR | | | 2a. DATE OF DEATH
MONTH 2 DAY 28 YEAR 87 | | | 2b. HOUR
7-05 M | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH 12 DAY 22 YEAR 1916 | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hampstead, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore Co. Gen. Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE
Maryland | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Westminster | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
534 Stone Rd. 21157 | |
| 14. FATHER'S NAME
FIRST Melchour MIDDLE Harris LAST Harris | | | | 15. MOTHER'S MAIDEN NAME
FIRST Edna MIDDLE Wagner LAST Wagner | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17 INFORMANT
Mary Ruby Harris | | ADDRESS
534 Stone Rd. Westminster, Md. 21157 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-26 19 87 , to 2-28 19 87 , that (I) (we) last saw the deceased alive on 2-28 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Govinda RAO | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2.28.87 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
GOVINDA RAO | | | | 23b. ADDRESS
BACT COUNTY Gme Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-3-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Westminster | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westminster Carroll Md. | | | |
| 24. FUNERAL DIRECTOR
Thomas D. Fletcher & Son | | | | 25. DATE REC'D. BY REGISTRAR
MAR 9 1987 | | | | | |
| 26. REGISTRAR'S SIGNATURE
Julia Swenson-Rudner | | | | | | | | | |

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047035 MAR 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8.7. 07409

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| FOR
STATE
REGISTRAR | | VIRGINIA | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
VIRGINIA HARRISON | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 7 87 | | 2b. HOUR
545 AM | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 9 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOS | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMRESS | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY
BALT. | | 13c. CITY OR TOWN
BALT | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1045 REVERDY RD 21212 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur TUCKER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HATTIE ROSE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
HATTIE GREEN 1045 REVERDY RD 21212 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Advanced respiratory disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Seizure et seiden</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrusum Accident (CVA)</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> , 19 <u>86</u> , to <u>3/7</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Mme Dm | | DEGREE
MO | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/7/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCUS | | 22e. ADDRESS
905 BALTIMORE Pkwy EC MD 21043 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-13-87 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown MD | | | |
| 24. FUNERAL DIRECTOR
NAME
March F.H. | | ADDRESS
EAST 1101 E. NORTH AVE. | | 25. DATE RECD BY REGISTRAR
MAR 12 1987 | | 25. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | | | |

MEDICAL CERTIFICATION

29

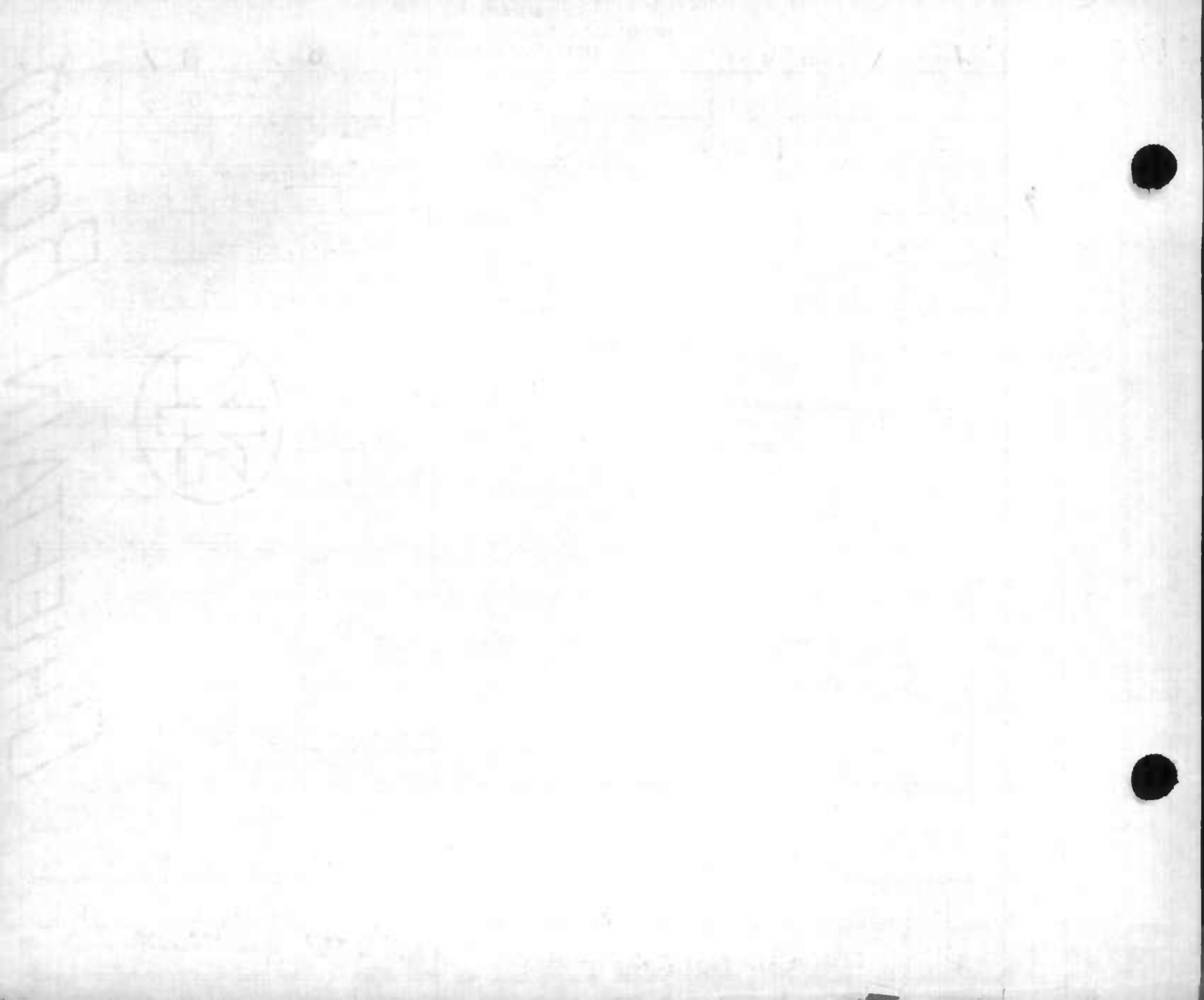
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



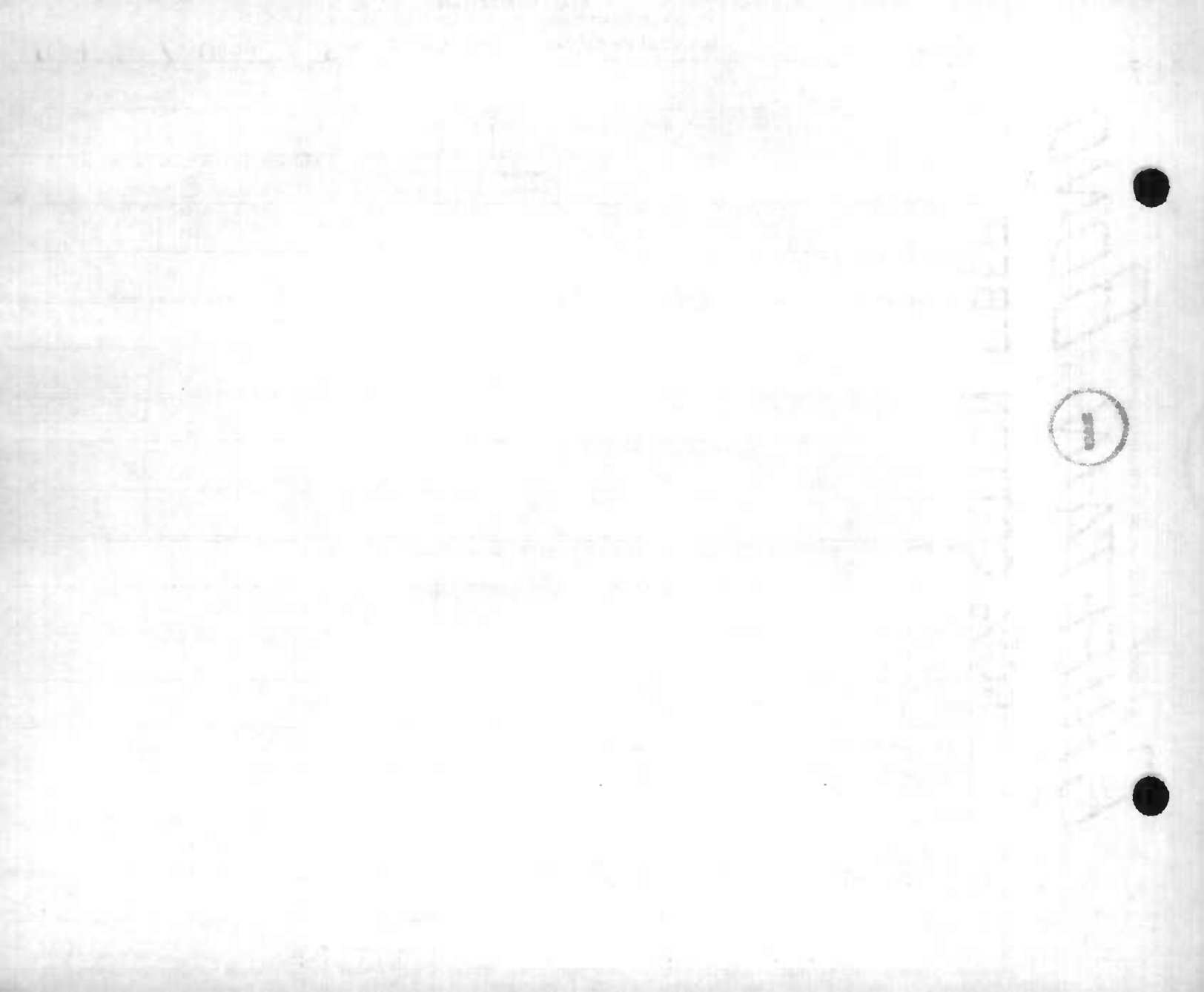
047840 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PH-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSFER PERMIT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07410 | |
|--|------------------|--|---|---|---|--|---|---|--|---|-------------------------|
| 1. DECEASED NAME
FIRST MIDDLE LAST
William Harrison | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
3/ 6/ 19 87 | 2b. HOUR
P M
8:48 |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
9 26 09 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
77 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3/ 6/ 19 87 | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
(Soc. Security) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
25 1/2 N. Fulton Ave. 21223 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Doc Harrison | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna McKinley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | (IF YES, GIVE WAR OR DATES)
WWII | | 16b. SOCIAL SECURITY NO.
102-18-6817 | | 17. INFORMANT
Leah Masson Grant | | ADDRESS
321 E. 25th Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia with Dehydration</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held in death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Charles P. Kokes</i> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
3/7/87 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
03-16-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Brown/Thompson F. H. | | | | ADDRESS
1913 W. Baltimore Street | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 19 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rudolph</i> | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



046882 MAR 12 1987

Items 18a thru 22a Filed 6-27-51

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO. 7 4 1

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Esther

Mae.

Hart

2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
3/ 7/ 19 87
2b. HOUR
M
a M

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

8 24 18

6. AGE (IN YEARS)

69 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3/ 7/ 19 87
2d. HOUR
4:30
a M

8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

North Carolina

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City, MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Sinai Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

U.S. Naval Academy

12b. KIND OF BUSINESS OR INDUSTRY

-

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

-

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

413 Roundview Rd. 21225

14. FATHER'S NAME

Richard

MIDDLE

Howell

LAST

15. MOTHER'S MAIDEN NAME

Anne

MIDDLE

Soloman

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

-

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

-

246-10-3659

17. INFORMANT

ADDRESS

Rosa Maynor 4910 Challedone Rd. 21207

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral anoxia with complications

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Interruption of oxygen supply

DUE TO, OR AS A CONSEQUENCE OF

(c) Error in connection of ventilator

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertensive arteriosclerotic cardiovascular disease, congestive heart failure, chronic obstructive pulmonary disease, chronic renal failure.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

disease, chronic renal failure.

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS:

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
3 P.M. 3 P.M. 19

20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Tubing on ventilator erroneously connected

21a. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21b. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.)

Hospital

21c. LOCATION

Maryland General Hospital, Baltimore City, MD.

22a. I certify that I took charge of the remains described above, held an

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from

Natural causes ☒Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 3/8/87

EXAMINER'S NAME
(TYPE OR PRINT)

Charles P. Kokes, M.D.

ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

3/12/87

23c. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

23d. LOCATION
CITY OR TOWN

Arbutus, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

W.C. March West 4300 Washab Ave.

25a. DATE RECEIVED BY REGISTRAR

MAR 11 1987

25b. REGISTRAR'S SIGNATURE

Julia D. Rader

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRINT IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1A AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BR 330

DHMH - 17
(VR A15 ME (5))



Cerebral

H

a n d

300

1000

X

X

1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

8 REG. NO. 07412

| | | | | | | | | | | |
|--|--|--|---|---|--------------------------------|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WESLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03/28/87 | | | 2b. HOUR
12:45 PM | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
06/10/18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.J. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Med. Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
laborer. | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1122 N. STOCKTON ST. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Shepherd | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218 038432 | | 17. INFORMANT
Marklene Hart | | ADDRESS
553 E 38th St. | | 21218 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Ca of the Lung, Extensive

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10-15 minutes
6 months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 10</u> , 19 <u>87</u> , to <u>March 28</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>March 27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Roland T. Smoot, M.D. | | | | DEGREE | | 22c. DATE SIGNED
3/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROLAND T. SMOOT, M.D. | | | | 22e. ADDRESS
2300 GARRISON BLVD. 21216 | | | |

| | | | | | | | |
|--|--|---------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
Burial | | 23b. DATE
4/1/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel MD | |
| 24. FUNERAL DIRECTOR
NAME
March Funeral Home | | | | ADDRESS
1101 E. NORTH AVE | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | | | |

1

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **07413**

FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|-------------------------|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jeffrey R. Hartman | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
3-4 1987 | | | 2b. HOUR
9:27 a.m. | | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
7-29-57 | 6. AGE (IN YEARS)
LAST BIRTHDAY
29 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
3-4 1987 | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital (STU) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Delivery | | 12b. KIND OF BUSINESS OR INDUSTRY
Domino Pizz | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 69 Seversky Ct. 21221 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley Hartman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Slawski | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
216-76-0533 | | 17. INFORMANT ADDRESS
Stanley Hartman Jr. 8308 Ridgely Rd. 21234 | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shotgun wound of abdomen
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

| | | |
|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
7:00am 3-4 1987 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot himself |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
69A Seversky Ct Baltimore City MD |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE **Margarita A. Korell** TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **3-4-87**

EXAMINER'S NAME (TYPE OR PRINT) **Margarita A. Korell, M.D.** ADDRESS **111 Penn St., Balto., MD 21201**

| | | | |
|--|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
3-7-87 | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Mary Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR
MAR 06 1987 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |
| 26. ADDRESS OF FUNERAL HOME
3331 Brehms Lane, Baltimore, Md. 21213 | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

ATLANTA, GEORGIA
JAN 10 1968
AIRTEL
TO: DIRECTOR, FBI
FROM: SAC, ATLANTA (100-100000)
SUBJECT: [illegible]

RECEIVED
JAN 10 1968
FBI - ATLANTA

100-100000

100-100000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 REG. NO. 07414

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
MARY ALICE HARTWIG | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 9 1987 | | 2b. HOUR
3 P. M. | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 24 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GARDEN VILLAGE NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. STATE
MD. | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MATTHEW HUNTER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY O'CONNOR | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-09-2084 | | 17. INFORMANT
ADDRESS
GILBERT HEATH (GRANDSON) 19 FERGUSON ST.
MILFORD, MA. 01757 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer Breast with metastasis to the lung</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Certified true</u> | | DEGREE
MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. NORICO | | 22e. ADDRESS
MERCY HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | 24. FUNERAL DIRECTOR
NAME SCHMUNEK FUNERAL HOME, INC. ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A

049263 APR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of remains. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO.

07415

| | | | | | |
|---|--|---|--|---|--|
| FOR
1 - STATE
REGISTRAR | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 30 1987 | | 2b. HOUR
P. 5:10 M. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Pauline Hatfield | | 3. SEX
Female | | 4. RACE
White | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
6-29-1909 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
77 YRS. | | 7. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Yugoslavia | | 7b. CITIZEN OF WHAT COUNTRY?
Yugoslavia | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belair Convalesarium | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael Renner | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Brucker | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
215-05-3912 | | 17. INFORMANT
ADDRESS
21239 | | 17b. BELVEDERE AVE.
1313 E. Belvedere Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CHRONIC LYMPHOCYTIC
DUE TO, OR AS A CONSEQUENCE OF LEUKEMIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: b
BRONCHITIS, SENILE DEMENTIA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/30 19 87, to 3/30 19 87, that (I) (we) last saw the deceased alive on 3/30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (and) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Luis E. Rivera | | DEGREE | | 22c. DATE SIGNED
3/31/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Luis E. Rivera, M.D. | | 22e. ADDRESS
5714 Harford Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland | |
| 23d. LOCATION
CITY OR TOWN
Balto., Md. | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
APR - 2 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Penderson | |

1000

March 21 1907

Chicago City

Postmaster

Post Office Box 1111

Chicago

Post Office Box 1111



Post Office Box 1111

Chicago

Chicago

Chicago

Post Office Box 1111

048927 APR -

17

FOR
STATE
REGISTRAR

EDITH M. HAUSTEIN

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO.

0-7-416

| | | | | |
|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDITH M. HAUSTEIN | | | 2a. DATE OF DEATH
MON 3 DAY 28 YEAR 87 HOUR 035 M | |
| 3 SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 5 DAY 31 YEAR 10 | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Presser | 12b. KIND OF BUSINESS OR INDUSTRY
Laundry |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Catonsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST John MIDDLE Knauff LAST Knauff | | 15. MOTHER'S MAIDEN NAME
FIRST Grace MIDDLE Keefer LAST Keefer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216101462 | | 17. INFORMANT
ADDRESS Catonsville, MD. 21228
Mary E. Heinicke - 1908 Logwind Rd. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) and stage congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia, pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF
(c) Renal failure
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
General peripheral vascular disease | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-26, 19-87 , to 3-27, 19-87 , that (I) (we) last saw the deceased alive on 3-27-19-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
EDITH M. HAUSTEIN | | DEGREE
MD | | 22c. DATE SIGNED
3-27-87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDITH M. HAUSTEIN | | 22e. ADDRESS
87 Agnes Hosp., BALTIMORE, MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
04-01-87 | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll MD. | |
| 24a. NAME OF FUNERAL HOME
Henry M. Russell C. Witzke Funeral Homes P.A. | | 24b. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | |
| 24c. ADDRESS
1630 Edmondson Ave., Catonsville, MD. 21228 | | 24d. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|
| 0.1 | 0.2 | 0.3 | 0.4 | 0.5 | 0.6 | 0.7 | 0.8 | 0.9 | 1.0 | 1.1 | 1.2 | 1.3 | 1.4 | 1.5 | 1.6 | 1.7 | 1.8 | 1.9 | 2.0 | 2.1 | 2.2 | 2.3 | 2.4 | 2.5 | 2.6 | 2.7 | 2.8 | 2.9 | 3.0 | 3.1 | 3.2 | 3.3 | 3.4 | 3.5 | 3.6 | 3.7 | 3.8 | 3.9 | 4.0 | 4.1 | 4.2 | 4.3 | 4.4 | 4.5 | 4.6 | 4.7 | 4.8 | 4.9 | 5.0 | 5.1 | 5.2 | 5.3 | 5.4 | 5.5 | 5.6 | 5.7 | 5.8 | 5.9 | 6.0 | 6.1 | 6.2 | 6.3 | 6.4 | 6.5 | 6.6 | 6.7 | 6.8 | 6.9 | 7.0 | 7.1 | 7.2 | 7.3 | 7.4 | 7.5 | 7.6 | 7.7 | 7.8 | 7.9 | 8.0 | 8.1 | 8.2 | 8.3 | 8.4 | 8.5 | 8.6 | 8.7 | 8.8 | 8.9 | 9.0 | 9.1 | 9.2 | 9.3 | 9.4 | 9.5 | 9.6 | 9.7 | 9.8 | 9.9 | 10.0 |
| 0.1 | 0.2 | 0.3 | 0.4 | 0.5 | 0.6 | 0.7 | 0.8 | 0.9 | 1.0 | 1.1 | 1.2 | 1.3 | 1.4 | 1.5 | 1.6 | 1.7 | 1.8 | 1.9 | 2.0 | 2.1 | 2.2 | 2.3 | 2.4 | 2.5 | 2.6 | 2.7 | 2.8 | 2.9 | 3.0 | 3.1 | 3.2 | 3.3 | 3.4 | 3.5 | 3.6 | 3.7 | 3.8 | 3.9 | 4.0 | 4.1 | 4.2 | 4.3 | 4.4 | 4.5 | 4.6 | 4.7 | 4.8 | 4.9 | 5.0 | 5.1 | 5.2 | 5.3 | 5.4 | 5.5 | 5.6 | 5.7 | 5.8 | 5.9 | 6.0 | 6.1 | 6.2 | 6.3 | 6.4 | 6.5 | 6.6 | 6.7 | 6.8 | 6.9 | 7.0 | 7.1 | 7.2 | 7.3 | 7.4 | 7.5 | 7.6 | 7.7 | 7.8 | 7.9 | 8.0 | 8.1 | 8.2 | 8.3 | 8.4 | 8.5 | 8.6 | 8.7 | 8.8 | 8.9 | 9.0 | 9.1 | 9.2 | 9.3 | 9.4 | 9.5 | 9.6 | 9.7 | 9.8 | 9.9 | 10.0 |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 REG. NO. 07417 | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MELVIN H HAYS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3-27-87 14 th M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 26 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) J. Deaton Medical Center And Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) First Mate | | 12b. KIND OF BUSINESS OR INDUSTRY Merchant Marine | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN BLT. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John W. Hays | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Johnston | | 13e. STREET ADDRESS / ZIP CODE 600 Light St. 21230 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-09-1591 | | 17. INFORMANT Ms. Mary Gibbons ADDRESS 3614 E. Northern Pkwy. Balto., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) MET. BLEEDING CA
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE A.W. Johnston | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.W. Johnston | | 22e. ADDRESS 120 S. GREENE ST. BALTO. 21207 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 3-28-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME State Anatomy Board | | | | ADDRESS Balto., Md. | | | |

NOV 10 1907

APR 1 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR
1 - STATE
REGISTRAR | | BESSIE F.
HEADLE | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 87 REG. NO. 07 | | 18 | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Bessie F Headle | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-22-87 | | 7b. HOUR
651 P.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
01/15/07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7a. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MED CNTR. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY HEADLE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY ROPA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
212189955 | | 17. INFORMANT
ADDRESS
JAMES HEADLE 3893 SINCLAIR LANE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>anoxic encephalopathy</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Rheumatic Heart Disease; IBD</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 17</u> , 19 <u>87</u> , to <u>March 22</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>March 22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert F. Commish</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-22-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert F. Commish | | | | 22e. ADDRESS
4940 Easton Ave Balto MD 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
03/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. --- MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>John</u> | | | | ADDRESS
1211 Chesapeake Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | | 25b. REGISTRAR'S SIGNATURE | |

Handwritten notes and diagrams on graph paper, including a large triangle and various mathematical symbols like $\frac{1}{2}$ and $\frac{1}{4}$.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or any unusual event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|---------------|--|--|
| 1- FOR STATE REGISTRAR | | 87 | | REG. NO. 07419 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Roger S. Hecklinger | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 15, 1987 | | | 2b. HOUR
M | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 9, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Villa St. Michael | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ind. Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Electrical | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
221 E. Northern Pkwy. 21212 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frederick E. Hecklinger | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Jennie Edwards | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
212 05 4510 | | 17. INFORMANT ADDRESS
Mrs. Elsie B. Hecklinger 221 E Northern Pkwy. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>COLON CANCER METASTATIC</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8/86 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> , 19 <u>86</u> , to <u>3/15</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARTHUR M. WOSNEN MD | | | | 22e. ADDRESS
3640 FOREST LANE BALTO 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

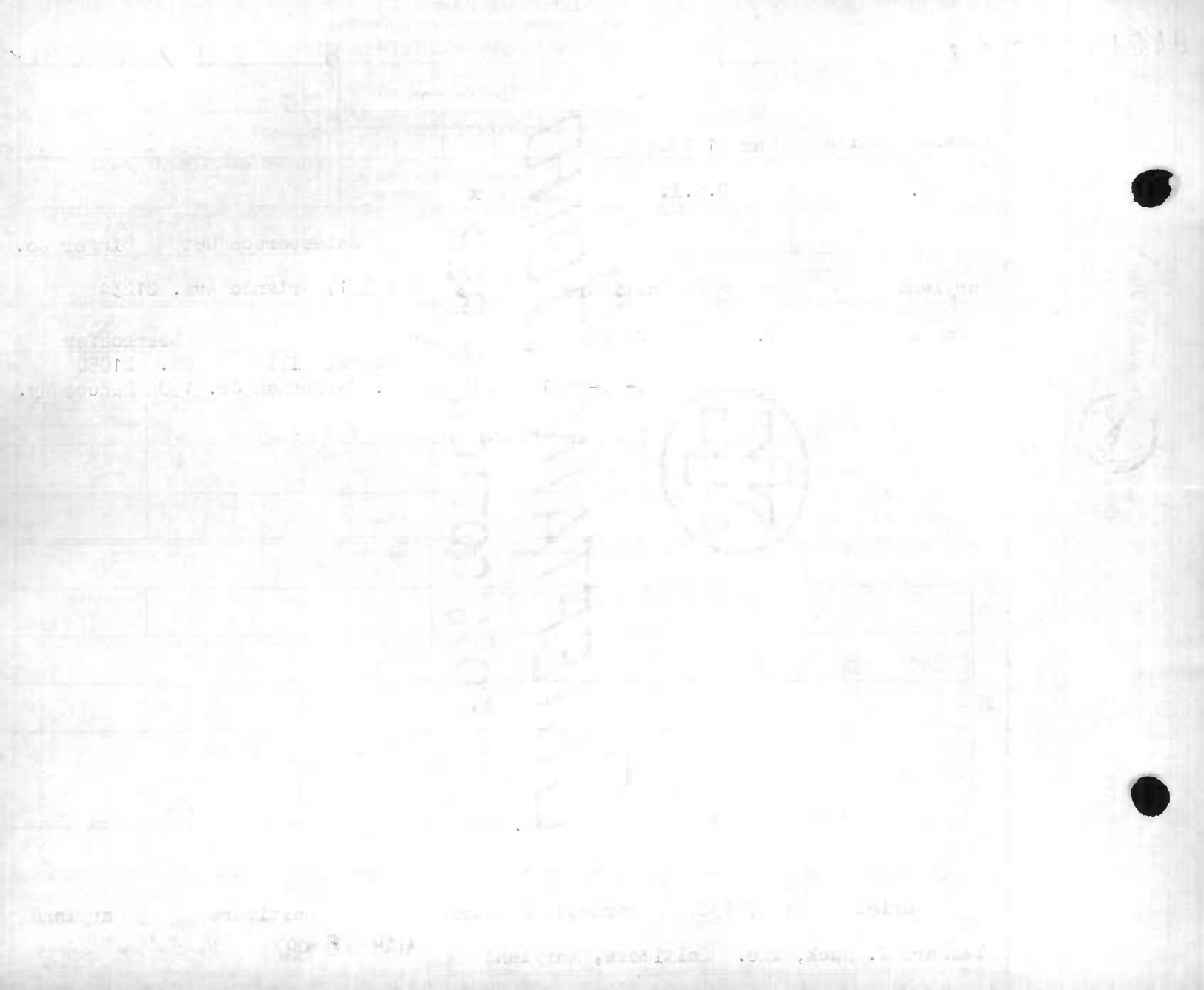
REG. NO. 87420

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|--|--|---|--|--|--|-----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MARY | | MIDDLE Z. | | LAST HEFFERNAN | | 2a. DATE KNOWN OF DEATH | | ESTIMATED MONTH DAY YEAR | | 3-4-87 19 | | 2b. HOUR M | | 3-4-87 19 5:30P | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR | | Mar 31 1904 | | 6. AGE (IN YEARS)
LAST BIRTHDAY | | 82 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | 3-4-87 19 5:30P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ky. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3217 Orlando Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesperson Ret | | 12b. KIND OF BUSINESS OR INDUSTRY
Singer Co. | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3217 Orlando Ave. 21234 | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST JAMES | | MIDDLE T. | | LAST CANARY | | 15. MOTHER'S MAIDEN NAME
FIRST LENA | | MIDDLE | | LAST DOERHOEFER | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
407-03-8641 | | 17. INFORMANT
Forest Hill ADDRESS Md. 21050
Raymond L. Heffernan Jr. 1906 Rencos Wy. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 3-5-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Mar 7 1987 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. | | | | ADDRESS
Baltimore, Maryland | | | | 25a. DATE REC'D BY REGISTRAR
MAR 06 1987 | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia D. Padale</u> | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CRIMINAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 87 REG. NO. 07421 | | 20. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| DECEASED NAME | | FIRST MIDDLE LAST | | 20. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| REGINALD | | H Heffner | | 3 | | 12 87 | | 11:5A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| M | | W | | MONTH DAY YEAR | | 77 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Kentucky | | USA | | | | Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | FSK Medical Center | | Retired | | Bethlehem Steel | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | Baltimore Dundalk | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7003 Dunhill Rd. 21222 | | | |
| FATHER'S NAME | | MOTHER'S MAIDEN NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| George | | Catherine | | Hardin | | no | | 217-07-1298 | |
| 17. INFORMANT | | ADDRESS | | 17. INFORMANT | | ADDRESS | | 21222 | |
| Carole Sue Meehan | | 1913 Robinwood Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) SQUAMOUS CARCINOMA OF LUNG | | | | | | | | 1 yr | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| R B SCOTT | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 3-12-87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| R B SCOTT | | MASON F. LORD HOSP. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN COUNTY STATE | |
| Burial | | 3/16/87 | | Oak Lawn Cemetery | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Connelly Funeral Home of Dundalk | | | | | | MAR 17 1987 | | Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon paper pages 1 and 2 and be filled in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be notified.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date of death.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8. REG. NO. 07422 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
LILLIAN L. E. HELMES | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 10, 1987 | | 2b. HOUR
4:55 PM | | | |
| 3. SEX
F | | 4. RACE
W. | | 5. DATE OF BIRTH MONTH DAY YEAR
4-23-1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
IF UNDER 23 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY - MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2430 E. FAYETTE ST. 21224 | | | | 14. FATHER'S NAME FIRST MIDDLE LAST
PHILLIP FISCHER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY ARNOLD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-48-2518 | | 17. INFORMANT ADDRESS
Mr. Edmund Opitz - F.O. 366
Richlands, Va. 24641 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> HOURS
DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERFORATED ULCER</u> HOURS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 9, 1987</u> to <u>MARCH 10, 1987</u> , that (I) (we) last saw the deceased alive on <u>MARCH 10, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Richard A. Josephson</i> | | | | DEGREE
M.D. | | 22c. DATE SIGNED
3-10-87 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD A. JOSEPHSON, M.D. | | | | 22e. ADDRESS
CHURCH HOSPITAL COPORATION
100 N. BROADWAY BALTIMORE, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3-13-87 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE
BALTO., MD. | | | |
| 24. FUNERAL DIRECTOR NAME
<i>Hartley Miller</i> | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 12 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

MEDICAL CERTIFICATION

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BAPTIST CHURCH
CHURCH
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FOR
STATE REGISTRAR IRESS I HELMICKSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07423

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
IDRESS I. HELMICK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 12 87 | | | 2b. HOUR
5:50A M | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 30 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
--- | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
(Unknown) Shifflet | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Effie Arbogast | | | 13e. STREET ADDRESS / ZIP CODE
1415 West Pratt St. 21223 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-10-4774 | | 17. INFORMANT
Louise Helmick | | ADDRESS
21223 W Cross St/Balto Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
(b) SEVERE EMPHYSEMA
DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE
(c) RENAL FAILURE | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3:14 P.M. 19 87 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
3/14 87 03/12 87 | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
3/14 87 | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3/14 87 03/12 87 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12 19 87 to 03/12 19 87 , that (I) (we) saw the deceased alive on 3/12 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Kuang-yen Huang | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
03/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KUANG-YEN HUANG M.D. | | | 22e. ADDRESS
Bon Secours Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
03/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie/AA Co/Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Walters Funeral Home/Pratt & Stricker Streets | | | ADDRESS
Balto Md 21223 | | | 25a. DATE REC'D. BY REGISTRAR
3-13-87 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove complete pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Concetta M. Hemmeter | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-1-87 | | | 2b. HOUR
1:55 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JULY 23, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO. MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY
BALTO. CO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
343 GROVE THORN RD. 21220 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOSEPH MAGGIO | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARIANNA DAMICO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-07-5795 | | 17. INFORMANT ADDRESS
FAMILY RECORDS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiogenic shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>cardiomyopathy</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>atherosclerotic coronary artery disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs.
years
years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>congestive heart failure, gastrointestinal bleeding, acute renal failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Melba Beine MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3-1-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Melba Beine | | | | 22e. ADDRESS
Mercy Hospital Baltimore MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3-05-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PARKVILLE BALTO CO. MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
EVANS CHAPEL OF MEMORIES | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 05 1987 | | 25b. REGISTRAR'S SIGNATURE
A. L. [Signature] | | | |

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(P)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove the certificate from this folder, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07425

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM K HENLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 17, 1987 | | 2b. HOUR
9:46P _M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4 1 17 | 6. AGE (IN YEARS (LAST BIRTHDAY))
69 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Typesetter | | 12b. KIND OF BUSINESS OR INDUSTRY
Sun Paper |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Md. 13a COUNTY Balto. | | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-09-3898 | 17. INFORMANT
5160 Balto. Nat'l. Pike - Balto., Md.
Mrs. Patricia L. Henley #21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pneumonia</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 mins.
24 hrs.
5 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<u>Thrombocytopenia / Hypoxia / Coronary Artery Disease</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AS WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> , 19 <u>87</u> , to <u>3/17</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Steven D. Datorre</u> | | DEGREE
MD | | 22c. DATE SIGNED
3/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Steven D. Datorre</u> | | 22e. ADDRESS
<u>JHH, 600 N Wolf St
Balt. Md 21205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Entombment</u> | | 23b. DATE
3-23-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Balto. | | COUNTY
Md. | | STATE | |
| 24. FUNERAL DIRECTOR
<u>G. Truman Seiwab</u> | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

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from

048653 MAR 31

17 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07426

| | | | | | | | | | |
|--|--|---|--|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HILARY A. HEROLD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 28 87 | | | 2b. HOUR
9:15 A.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
09-19-32 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA (MD) | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired. | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| 13a. STATE
Md | | | 13b. COUNTY
BC | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Herold | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leona Sable | | | 13e. STREET ADDRESS / ZIP CODE
3005 E. Monument ST, BALTO. 21205 | | | |
| 16a. WAS DECEASED A MEMBER OF U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | | 16b. SOCIAL SECURITY NO.
219289798 | | 17. INFORMANT
CHARLIE VIRGINIA LUTZ
ADDRESS
SAME AS 13c | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute myocardial infarction with
Cardiogenic Shock
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hypertensive Arteriosclerotic Heart Disease, previous Myocardial Infarction | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22, 19 87, to 3/28, 19 87, that (I) (we) last saw the deceased alive on 3/28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ana Maria Martinez MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
3/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANA MARIA MARTINEZ MD | | | | 22e. ADDRESS
300 I. S. HANOVER ST, BALTO, MD, 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(BY)
BORIAL | | 23b. DATE
3-31-87 | | 23c. NAME OF CEMETERY OR CREMATORY
GLENHAVEN MEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | | |
| 24. FUNERAL DIRECTOR
NAME
HOFFMANN-SKARDA | | | | ADDRESS
3218 HUDSON ST | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

07427

1. FOR
STATE
REGISTRAR

8 REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|---------------------|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William Eugene Herron | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 20, 1987 | | 2b. HOURS
8:00 M | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4/3/1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3900 Fairhaven Ave., Apt 2 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Welder | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel Bethlehem | | | |
| 13a. STATE
Md. | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Neal Herron | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Lawson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
223-26-3718 | | 17. INFORMANT
ADDRESS Balto., Md. 21226
Naomi P. Norris 3828 Fairhaven Ave. | | | | | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on 3/3 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Colum C. Carter, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Drs. Gehlert, Carter, & Fisher | | | | 22e. ADDRESS
4710 Pennington Ave., Balto., Md. 21226 | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A.A. Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Homes Balto., Md. 21226 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been used by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then place in the envelope carrier papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

BP

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RECEIVED

10000

[Faint, illegible handwritten text, possibly a ledger or account book entry]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner should be notified and a report filed.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8707428

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
Baby Girl Hicks | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 30 87 | | 2b. HOUR
1:00A.M. | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 29 87 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
5 55 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital Inc. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Newborn | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. COUNTY
BALT | 13c. CITY OR TOWN
Balto | 13d. STREET ADDRESS / ZIP CODE
3020 Reisterstown Rd Balto Md 21221 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Donald Diggs | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cheryl Hicks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
Linda Henn Sinai Hospital Inc. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Prematurity</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 29</u> , 19 <u>87</u> , to <u>March 30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>E. Y. Johnson MD</u> | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3-30-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>E. Y. Johnson MD</u> | | 22e. ADDRESS
<u>Sinai Hospital Greenspring at Belvedere 2715</u> | | | |
| 23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>
(SPECIFY) | 23b. DATE
<u>4-7-87</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>SINAI HOSPITAL</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>BALTO MD</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>SINAI HOSPITAL 2401 W. BELVEDERE AVE</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>APR 10 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Swinton-Randall</u> | |

BP

4/15

048918 APR - 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07429

| | | | | | |
|---|---|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>LAVADA</u> MIDDLE <u>A</u> LAST <u>HICKS</u>
<u>LAVADA HICKS</u> | | 2a. DATE OF DEATH
MONTH <u>3</u> DAY <u>27</u> YEAR <u>1987</u> | | 2b. HOUR
M | |
| 3. SEX
<u>F</u> | 4. RACE
<u>B</u> | 5. DATE OF BIRTH
MONTH <u>11</u> DAY <u>4</u> YEAR <u>1901</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>85</u> YRS. | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | IF UNDER 24 HRS.
HOURS <u></u> MIN. <u></u> |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<u>GA, USA</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>BALTIMORE CITY</u> MD. | | |
| 10. CITY OR TOWN OF DEATH
<u>BALTIMORE</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>BON SECOURS</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>RETIRED</u> | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
<u>MD</u> | 13b. COUNTY
<u>BALTIMORE</u> | 13c. CITY OR TOWN
<u>BALTIMORE</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<u>2820 Riggs Ave. 21216</u> | |
| 14. FATHER'S NAME
FIRST <u>AUGUSTUS</u> MIDDLE <u></u> LAST <u>JACKSON</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>JANNIE</u> MIDDLE <u></u> LAST <u>JACKSON</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>216244163</u> | | 17. INFORMANT
ADDRESS
<u>Clarence Hicks 4302 1/2 Norfolk Ave. 21216</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ADVANCED Respiratory Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL VASCULAR Accident</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>3</u> <u>6</u> <u>19</u> <u>87</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> 19 <u>87</u> , to <u>3/27</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Mark Davis</u> | | DEGREE <u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/28/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>MARK DAVIS</u> | | 22e. ADDRESS
<u>9051 BALTIMORE PK E.C. MD 21243</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>4-1-87</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arbutus Gm.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Arbutus MD</u> |
| 24. FUNERAL DIRECTOR
NAME <u>March Funeral Home</u> ADDRESS <u>1101 E. North Ln</u> | | | | | |
| 25a. DATE REC'D BY REGISTRAR <u>MAR 30 1987</u> 25b. REGISTRAR'S SIGNATURE | | | | | |

BP



46756 MAR 11

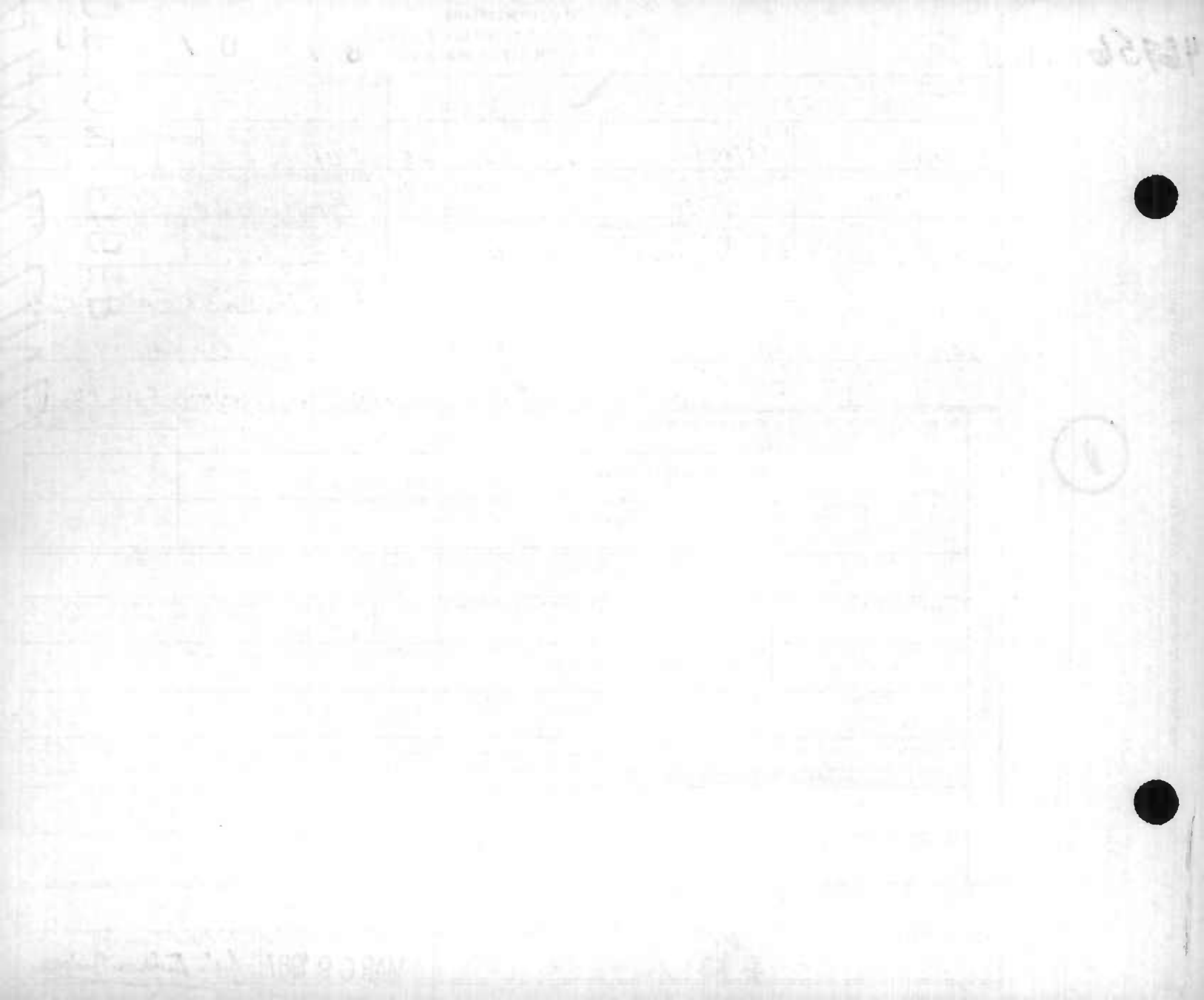
1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07430
REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MANIE L. HILL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/6/87 | | | 2b. HOUR
5:55 AM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 02 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61
YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMP. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES M. Hill | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE B. Cunningham | | | 16. STREET ADDRESS / ZIP CODE
3014 Gwynns Falls Pkwy | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
-
UNKN | | 17. INFORMANT
ADDRESS
Estell Jacoby 3014 Gwynns Falls Pkwy. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
L. Hill | | | | | DEGREE | | 22c. DATE SIGNED
3/6/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEPHORIA C. AUTO | | | | | 22e. ADDRESS
LIBERTY MEDICAL CENTER | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Nat. Pk. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laurel Md. | | |
| 24. FUNERAL DIRECTOR
NAME
W.C. March F/H West 4300 Wabash Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 09 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Tindon-Budaca | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.
TO THE REGISTRAR: This certificate is to be filed with the State Dept. of Health and Mental Hygiene.



BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

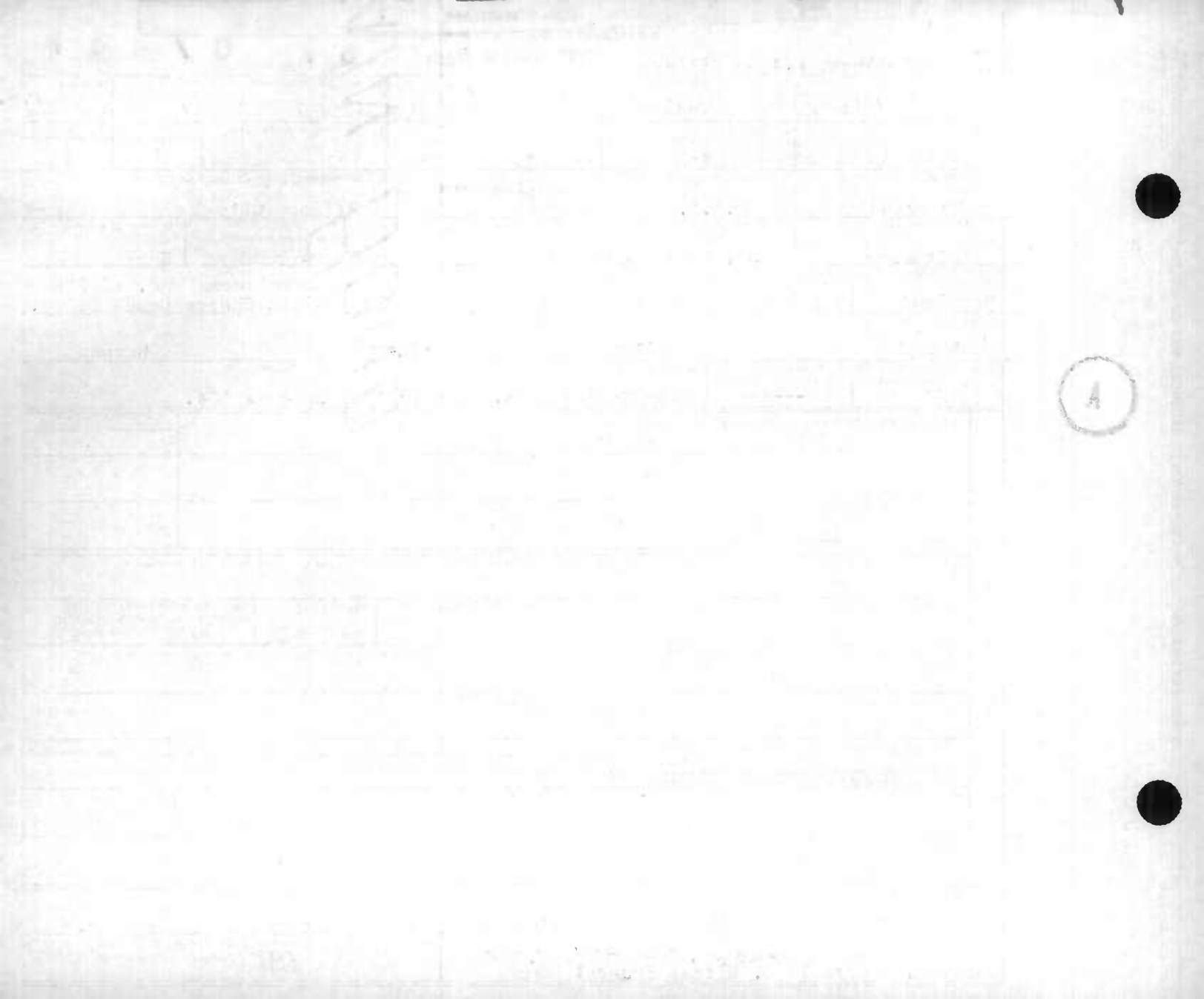
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR Albert Wilson Hiller | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Albert Wilson Hiller | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/29/87 3/29/87 | | 2b. HOUR
4⁴ A.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 25 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
warehouse receiver | | 12b. KIND OF BUSINESS OR INDUSTRY
Sears | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Md. 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Hiller | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Murphy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-10-5345 | | 17. INFORMANT
ADDRESS
Mrs. Mary Hiller Same as 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3/29 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/29 1987 to 3/29 1987 , that (I) (we) last saw the deceased alive on 3/29 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ziad Rifai | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ziad Rifai | | | | 22e. ADDRESS
St Agnes Hospital 900 Caton Avenue | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/1/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
1630 Edmondson Ave. Catonsville, Md. 21228
Leroy M. & Russell C. Witzke Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
J. H. Davidson-Randall | |



046326

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07432

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--------------------------------------|--|--------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| George | | | | | | Hines | | 3 | | - | | 19 | | 87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| M | B | 3/21/23 | | 63 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 3-4 | | 1987 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| ROCKY MT., N.C. | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 100 Blk S. Calverton | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD | | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21216
1306 N. BENTALOU ST. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| JOHNNIE HINES | | JENNIE BATTLE | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| YES | | WWII | | 215-16-0694A | | RITA BROOKS 975 WAYSIDE DR. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Alcoholism with fatty liver</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | DATE
SIGNED 3-4-87 | | | | | | | | | |
| ACTUAL
SIGNATURE | | EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | |
| Gregory R. Kauffman, M.D. | | 111 Penn St., Balto., MD | | 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| BURIAL | | 3/7/87 | | CROWNSVILLE, VET. CEM. | | CROWNSVILLE, MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| LEROY O. DYETT 4600 LIBERTY HEIGHTS | | | | MAR 05 1987 | | Julia Davidson-Randall | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified of once.

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1

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07433 | | | |
|---|--|---|--|--|--|---|--|
| 1- STATE REGISTRAR 3/30/87 rja | | | | FOR Film G625 item 5, 22a | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
EUGENE J. HOBAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3/14/87 2b. HOUR 4:25 P.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore city | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE 2736 Brendan Avenue 21213 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael A. Hoban | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McCormick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 195-20-1339 | | 17. INFORMANT ADDRESS Catherine A. Hoban 2736 Brendan Ave 21213 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of colon with multiple Metastasis
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10/87 to 3/14/87, that (I) (we) last saw the deceased alive on 3/14/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Marcos B. Galicia Jr. MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS B. GALICIA JR. MD | | | | 22e. ADDRESS North Charles General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Mar 17 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 16 1987 | | | |

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10/1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1, page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELEANOR M. HOFFMAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 4 1987 | | | | | 2b. HOUR
10:45 AM | |
| 3 SEX
female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
March 31, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
(unknown) | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Postal Clerk(ret) | | | 12b. KIND OF BUSINESS OR INDUSTRY
US Civil Serv | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE COUNTY
MD Montgomery | | | | | 13b. CITY OR TOWN
Gaithersburg | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
Asbury U/Methodist Apts. 20760 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William H. Hoffman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lillian H. Shaffer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
XXXXXXXXXX | | 17. INFORMANT
Rev. Donald Llewellyn (Pastor) | | ADDRESS 200 School Lane
Linthicum, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ORGANIC Brain Syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Depression, etc.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 3</u> 19 <u>87</u> to <u>MARCH 4</u> 19 <u>87</u> , that (I) (we) lost saw the deceased <u>live on</u> <u>MARCH 4</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>SCOTT RIFKIN</u> | | | | | DEGREE
<u>M.D.</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<u>MARCH 4, 1987</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SCOTT RIFKIN, M.D. | | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
6 March 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Prince Georges MD. | | | |
| 24. FUNERAL DIRECTOR
NAME <u>R. H. Jackson</u> ADDRESS
Singleton Funeral Home, Glen Burnie, MD | | | | | 25a. DATE REC'D BY DEPT. MAR 25 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Gordon-Randall</u> | | | | |

BP _____

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other (1) (b) (2) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07436

| | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Emma L Holmes | | | 2a. DATE OF DEATH MONTH DAY YEAR
03 26 87 | | | 2b. HOUR
12 20 AM | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 19 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Leon | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl | | | 13e. STREET ADDRESS / ZIP CODE
4800 Seton Dr. 21215 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
238-20-7594 | | 17. INFORMANT ADDRESS
Rosalie Chernock 2603 Lightfoot Dr. 21209 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Obstructive Pulmonary Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 87 , to 3/26 , 19 87 , that (I) (we) last saw the deceased alive on 3/26 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
SAM MILLER | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SAM MILLER MD | | | 22e. ADDRESS
SINAI HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
3/27/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Balto Md. | | |
| 24. FUNERAL DIRECTOR
Harry H Witzke
& Family Funeral Home Inc. Ellicott City, Md. | | | | | 25a. DATE REC'D BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 56.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 8 REG. NO. | | 07437 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FRANCES HOLMES | | | | | 2a. DATE OF DEATH
MARCH 9, 1987 | | | 2b. HOUR
10:45 PM | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
SEPT 16, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
LOUISIANA | | 7b. CITIZEN OF WHAT COUNTRY?
US of A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4623 BELVUE AVE. 21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ARTHUR BRADFORD | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY ANTOINE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216 24 2313A | | 17. INFORMANT ADDRESS
MRS. MARY H. FRANCIS 4623 BELVUE AVENUE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) PNEUMONIA, SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) MULTIPLE ORGAN FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
CHRONIC OBSTRUCTIVE LUNG DISEASE, PERIPHERAL VASCULAR DISEASE, CHRONIC HEART FAILURE, CARDIOVASCULAR ACCIDENT, DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION
JANUARY 1, 1987 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ISCHEMIC RIGHT LEG | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (if this hospital) attended the deceased from JANUARY 5, 1987 to MARCH 9, 1987 that (if we) lost saw the deceased alive on MARCH 9, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (a) (did) (did not) view the body after death. | | | | | | | | | |
| 23a. SIGNATURE
<i>Carlos Sacasa</i> | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/10/87 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
CARLOS SACASA MD. | | | | 22e. ADDRESS
c/o MARYLAND GENERAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julian Francis Rucker</i> | | | |

1997, 2000

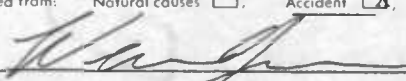
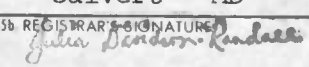
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

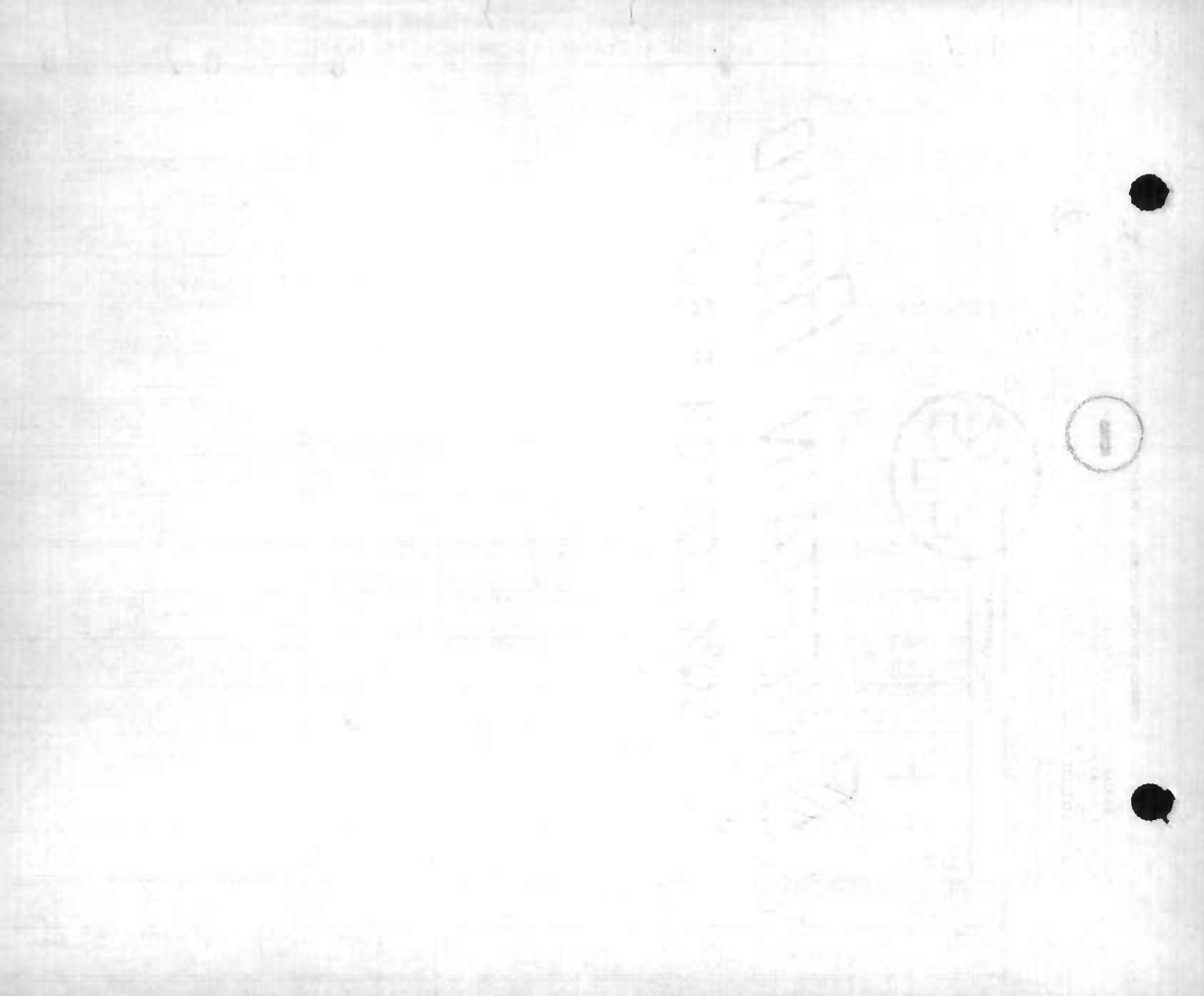
REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|-----------------|--|--|---|--|----------------------------------|--------------|-------------------------------|--|--|--|--|--|---|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
JOSEPH | | | MIDDLE
Miller | | | LAST
HOOK | | | 2a. DATE OF DEATH
KNOWN
ESTIMATED <input checked="" type="checkbox"/> 3 13 19 87 | | | 2b. DATE OF DEATH
PRONOUNCED
DEAD 3 13 19 87 | | | 2c. DATE OF DEATH
PRONOUNCED
DEAD 3 13 19 87 | | | 2d. HOUR
10:00 AM | | | | | | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 05 01 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
85 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital (STU) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | | | | | | | | | | | |
| 13a. STATE
MD | | | | 13b. COUNTY
Calvert | | | | 13c. CITY OR TOWN
North Beach | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
3849 4th Street/20714 | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Abraham Lincoln Hook | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marion Miller | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
n/a | | | | | | 17. INFORMANT
ADDRESS
Alverta Tulgetske same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple injuries with complications</u>
7 8150
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10:34xx 3-6- 1987 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Driver of auto/fixed object impact. | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/B Rt. 2 near, Owing, Calvert MD
wayside Dr. | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED
3-14-87 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
William M. Zane, M.D. | | | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | | 23b. DATE
3-17-87 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Southern Mem. Gardens | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dunkirk, Calvert MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Rausch FH | | | | | | | | | | | | ADDRESS
Box 45 Owings, MD 20736 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | | | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



RELEASED NON MED PER MR. GREGORY

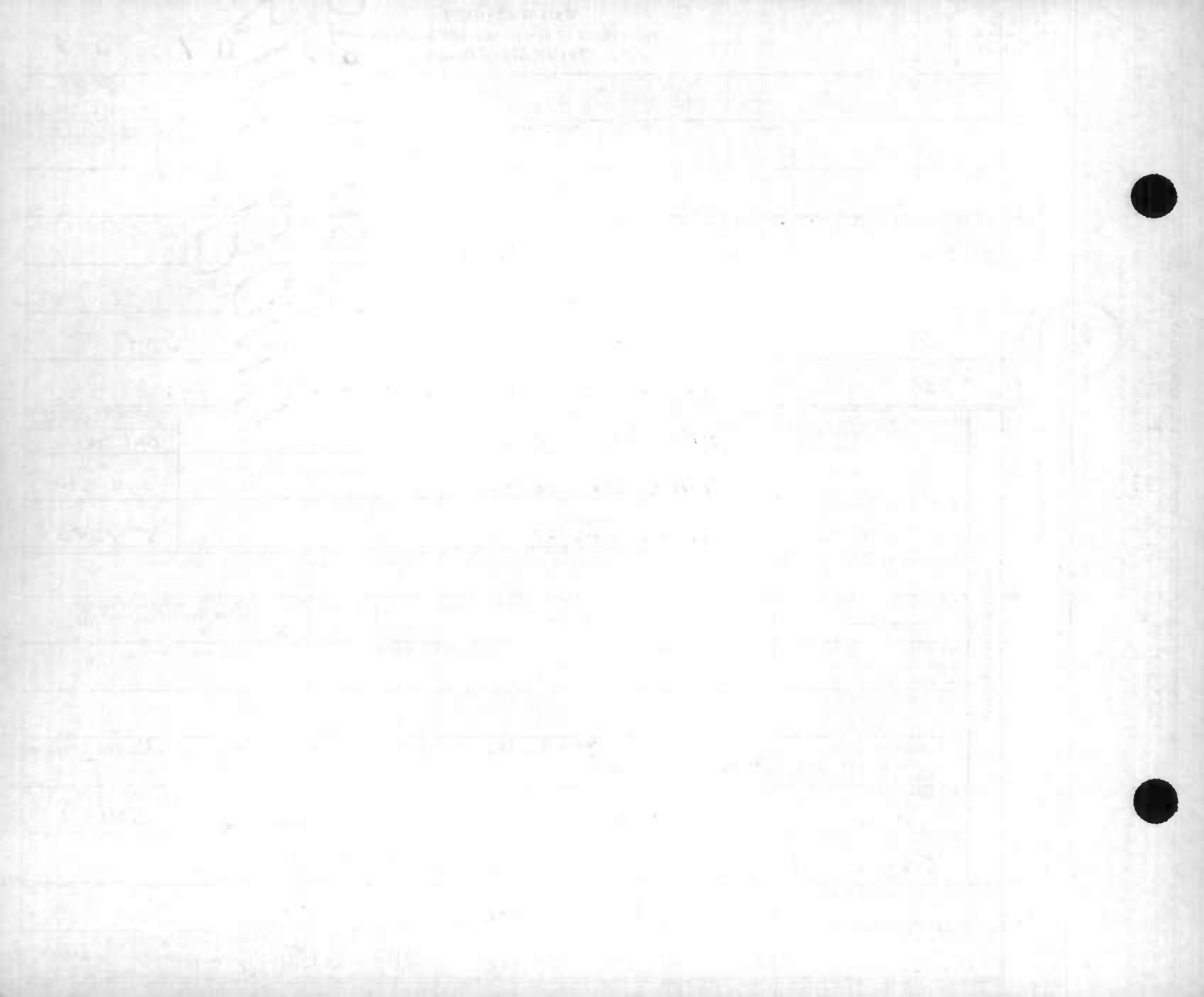
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
OTIS HOPKINS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 31, 1987 | | 2b. HOUR
11:03A | | | |
| 3 SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 25 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Tommy Hopkins | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Betsy Carter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
240-44-1069 | | 17. INFORMANT ADDRESS
Marie Edmonds 2709 E. Federal St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PULMONARY EDEMA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>RENAL FAILURE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>ONE HOUR</u>
<u>ONE DAY</u>
<u>5 YEARS</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 31, 1987</u> to <u>MARCH 31, 1987</u> , that (I) (we) lost
saw the deceased alive on <u>MARCH 31, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert A. Luke MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/31/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT A. LUKE, MD | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 6 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Sanders-Rudner</u> | | | | |



046609

16b., G-625, 3/16/87 by
FOR
STATE F.H., & Afvid.,
REGISTRAR Gbj.
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07440:45

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Robert R. Hopkins | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 08 97 | | 2b. HOUR
5:45 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
01 12 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balti. City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SBGH | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
INVESTIGATOR | 12b. KIND OF BUSINESS OR INDUSTRY
BB & C |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
MD | 13b. COUNTY
AA | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
153 OLAN DR. 21061 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Harvey Hopkins | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Margaret Riley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO
217-28-8472 | | 17. INFORMANT
ADDRESS
Helen L. Hopkins, same as 13 |

| | | | |
|---|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Resp. Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (c) Mediastinitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
Pulmonary fibrosis | | | |
| 19a. DATE OF OPERATION
3-26-87 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Esophageal stricture | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-15-87 , to 3-8-87 , that (I) (we) last saw the deceased alive on 3-8-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Arguillano | | DEGREE
MD | 22c. DATE SIGNED
3-8-87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. R. Arguillano | | 22e. ADDRESS
SBGH | |

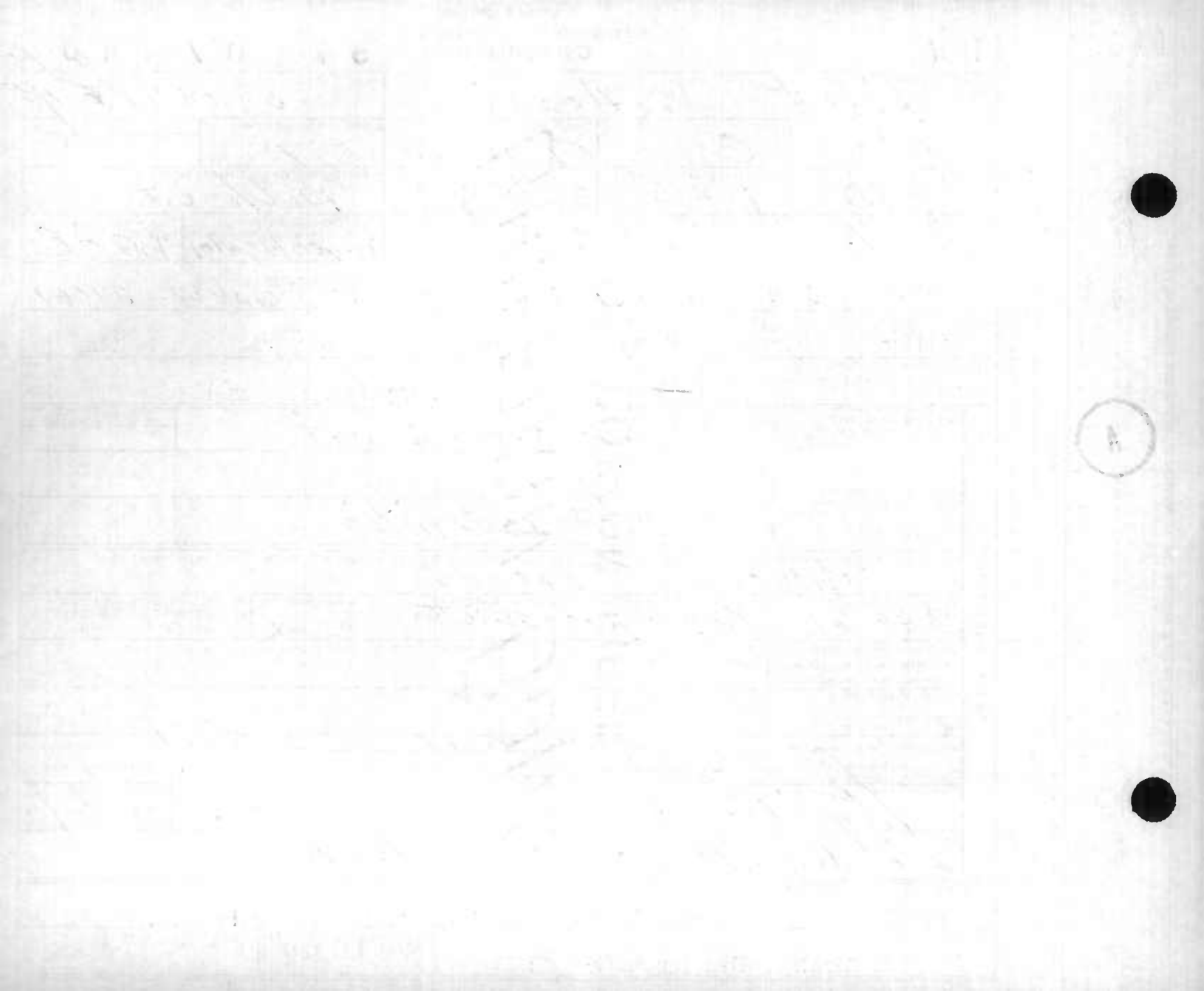
| | | | |
|---|---------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
11 March 87 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. MD |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
James S. Kirkley, Glen Burnie MD 21061 | | 25. D. REC'D. BY REGISTRAR
MAR 10 1987 | 25b. REGISTRAR'S SIGNATURE
John P. Pudeale |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



047764 MAR 23

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE COMPLETED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED FOR BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 07441

| | | | | | | | |
|---|---|--|---|---|-----------------------------------|-----------------------------------|------------|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 3-17 1987 | | M | |
| Willis J. Horner | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 2d. HOUR |
| Male | White | 9 14 09 | 77 YRS. | MONTHS DAYS | HOURS MIN. | 3-17 1987 | 10:40 a.m. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Md. | U. S. A. | | | Baltimore City, | | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | 4732 Dartford Avenue | | Retired-Truck Driver | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| Md. | | | Balto. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Balto., Md. | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| Damon | | Bessie Jane Kelly | | 16b. SOCIAL SECURITY NO. | | | |
| | | | | 216-03-8520 | | | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Mrs. Mary E. Horner | | PART I DEATH WAS CAUSED BY: | | | | | |
| | | IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (b) _____ | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) _____ | | | | | |
| | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| | | Chronic Obstructive Pulmonary Disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, and an | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | |
| death resulted from | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | DATE | | DATE | | | |
| Dennis F. Smyth, M.D. | | 3-17-87 | | 3-17-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn St., Balto., Md. 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | Mar. 20, 1987 | | Meadowridge Cemetery | | COUNTY STATE | |
| | | | | | | Howard, Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| G. Truman Seiwab | | MAR 19 1987 | | | | | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

G. Truman Seiwab

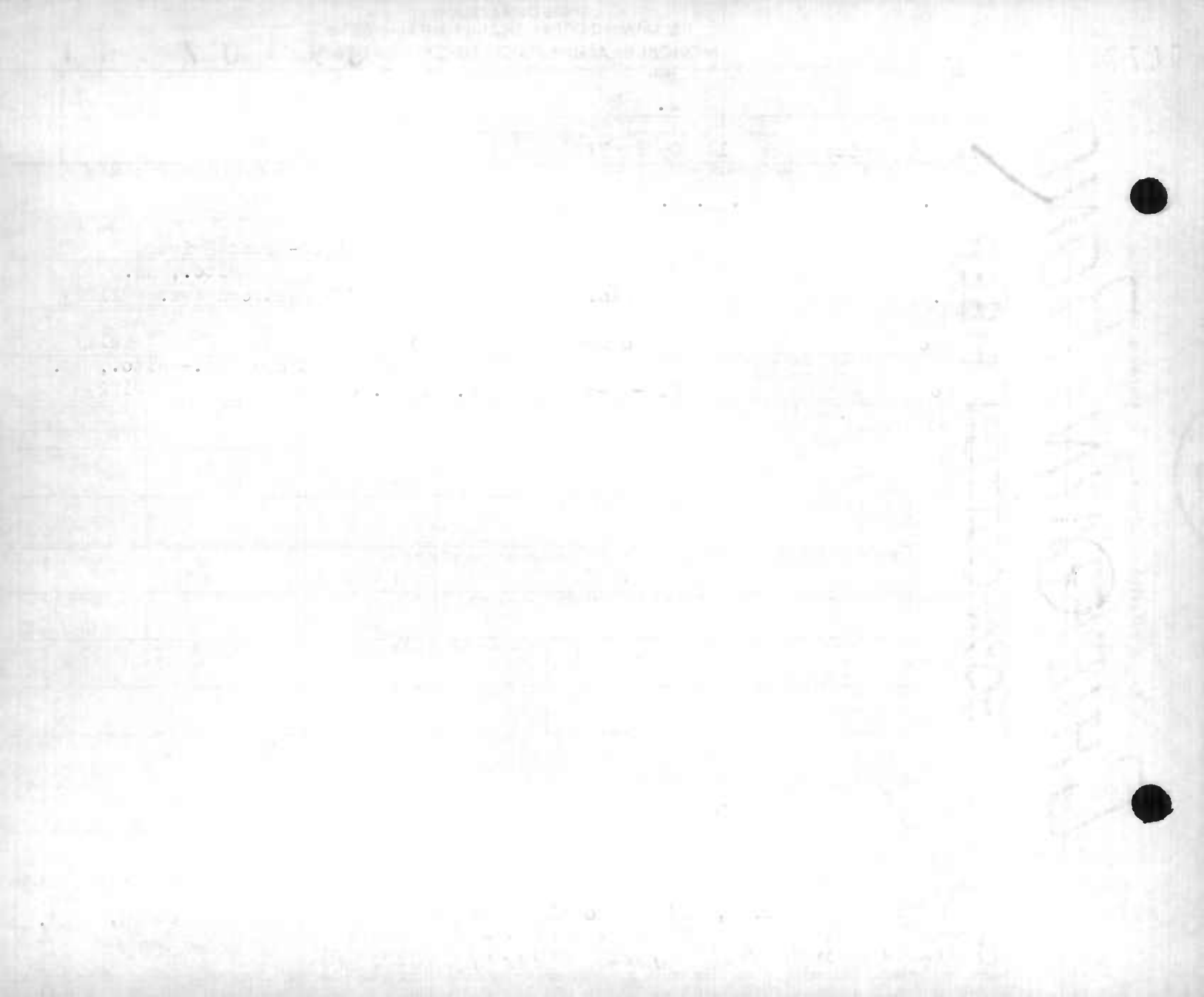
ADDRESS

5151 BAYVIEW NATL PIKE #21229

MAR 19 1987

DATE REC'D. BY REGISTRAR

REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must remain carbon papers; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY A. HOUGHTLING | | | | | 2a DATE OF DEATH MONTH DAY YEAR
3/6/87 | | | 2b HOUR
2010 M | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR
6/10/1910 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.
76 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSP. 900 CATON AVE. | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
LINCOLN | | 13b COUNTY
A.A. COUNTY | | 13c CITY OR TOWN
LINCOLN | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
408 NANCY AVE. (21090) | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Robert Montgomery | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary A. Mandley | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 16b SOCIAL SECURITY NO.
218-36-1491 | | 17 INFORMANT ADDRESS
Ida Fick, 408 Nancy Ave., Linthicum, MD (21090) | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Hx of Arrhythmia, Hx of Unstable Angina, Hx CAD, Hx CHF, Mitral Regurgitation, Renal Fail.</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3/2</u> , 19 <u>87</u> , to <u>3/6</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<u>Robert S. Atac</u> | | | | | DEGREE
<u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Robert S. Atac</u> | | | | | 22e ADDRESS
<u>St. Agnes Hospital</u> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b DATE
3-9-1987 | | 23c NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Pk., A.A.Co., MD | | |
| 24 FUNERAL DIRECTOR NAME
George J. Gonce, 4001 Ritchie Hg. Balto. | | | | | 25a DATE REC'D BY REGISTRAR
MAR 09 1987 | | | | |
| ADDRESS
(21225) | | | | | 25b REGISTRAR'S SIGNATURE | | | | |

BP

048469 MAR 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07443 | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
[TYPE OR PRINT] CELESTINE HOWARD | | | | 2a. DATE OF DEATH
MONTH DAY YEAR HOUR
3 21 87 2:45 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 7 93 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
? | | 7b. CITIZEN OF WHAT COUNTRY?
? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE md. 13b. CITY BALTO. 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7355 Furnace Branch Rd. 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Rudolphus Williams | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLA Jones | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO.
220-01-3775 | | 17. INFORMANT
NAME ADDRESS
Celestine Brooks Cedar Hill 21225 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of breast
DUE TO, OR AS A CONSEQUENCE OF (b) Ca. of breast
DUE TO, OR AS A CONSEQUENCE OF (c) Ca. of breast
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
② Dehydration / malnutrition ③ infected wounds | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3/23 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21 87 to 3/21 87 , that (I) (we) lost saw the deceased alive on 3/21 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
ng ooley, M.D. | | 22c. DATE SIGNED
3/23/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ng ooley, M.D. | | | |
| 22e. ADDRESS
1631 DUNDY HILL AVE | | 22f. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
A. H. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Oden & Gibson | | 24b. ADDRESS
1631 DUNDY HILL AVE | | 24c. SIGNATURE
Julia Denton | | | |

RECEIVED
MAY 10 1964

[Faint, mostly illegible handwritten text and markings across the page]

(A)

[Handwritten scribble or signature]

RECEIVED
MAY 10 1964

047607 MAR 18

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07444

| | | | | | | | | | |
|--|-------------------------|--|--|---|---|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
HEATHER L. HOWARD | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
3 14 19 87 | | | 2b. HOUR
4:08 P M | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 3 1967 | 6. AGE (IN YEARS LAST BIRTHDAY)
19 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3 14 19 87 | 7d. HOUR
4:08 P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital (STU) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Owings Mills | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS
12236 Greenspring Ave. | | 13f. CITY OR TOWN
21117 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley E. Howard | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Patricia L. Roller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-96-2519 | | 17. INFORMANT ADDRESS
Stanley E. Howard, same as 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
8151
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
Instant YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
11:30 3-13- 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Passenger of van/fixed object impact. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
York Rd. so. of, Cockeysville, Balto. MD
Phoenix Rd. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
<i>William M. Zane</i> | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | DATE SIGNED 3-15-87 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
William M. Zane, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
3/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Bryan W. Clary, 10 W. Padonia Rd., 21093 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Bryan W. Clary</i> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 17. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

20% COTTON FIBER

WATER-RESISTANT



047197 MAR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 REG. NO. 07445 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2b. HOUR | | | |
| Rosalie (NMN) Howe | | | | 3 - 12 - 87 1238 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | Feb. 24 1918 | | 69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S.A. | | | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Union Memorial Hospital | | Unemployed | | - | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. CITY OR TOWN | | | |
| 13a. STATE | | | | 13b. COUNTY | | | |
| Md. | | | | Baltimore | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Louis Merlo | | | | Justine Teresa | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | 219-01-8340 | | Frances Vitilio (sister) same address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | 2 1/2 hr |
| IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| (b) unknown | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | |
| unknown | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| none | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-11, 1987, to 3-12, 1987, that (I) (we) lost saw the deceased alive on 3-12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| L. Olding MD | | | | | | 3-12-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| L. OLDING | | | | Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 3/14/87 | | Holy Redeemer | | Baltimore Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | MAR 13 1987 | | | |

BP

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and appropriately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|--|
| Items 3-7a per phone
FOR 4/9/87 DAB
1- STATE REGISTRAR | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Hope BABY GIRL Marie HOWELL | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 24 87 | | | 2b. HOUR
12 ¹⁵ AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
3 26 87 | | 6. AGE (IN YEARS LAST BIRTHDAY)
22 under section YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3958 Falls Road 21211 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Georgia Howell | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>severe immaturity (22 wk fetus)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>premature labor & premature rupture of membranes</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ob membranes</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Rita Lead, M.D. | | | | | | DEGREE | | | 22c. DATE SIGNED
3-29-87 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Rita Lead, M.D. | | | | | | 22e. ADDRESS
UMH Baltimore MD 21218 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
4-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME
State Anatomy Board | | | | | | ADDRESS
Balto., Md. | | | 25a. DATE REC'D. BY REGISTRAR
APR 03 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Rudner | |

A

4/10

APR 03 1977

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07447

REG. NO.

| | | | | | |
|---|--|---|---|----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 20. DATE OF DEATH MONTH DAY YEAR | |
| ELEANOR MARGARET HRICHAK | | MARCH 9, 1987 | | 3:40A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| FEMALE | WHITE | FEBRUARY 1, 1923 | 64 YRS | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| PENNSYLVANIA | U.S.A. | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | ST. AGNES HOSPITAL | CASHIER | PANTRY PRIDE | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | BALTIMORE | BALTIMORE | | 1123 WILSON AVENUE 21207 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | |
| PAUL BROBST | SADIE EDWARDS | | NO | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | |
| 169-18-4507 | MICHAEL HRICHAK | SAME AS # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) <u>CONGESTIVE HEART FAILURE</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) <u>PNEUMATIC HEART DISEASE - MITRAL VALVE</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| <u>POOR ORAL INTAKE, PROBABLE CORONARY ARTERY DISEASE</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 18, 1985</u> to <u>March 9, 1987</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1987</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Damian E. Birchess M.D.</u> | | | | 3/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | 22f. DATE SIGNED BY REGISTRAR | | |
| Damian Birchess M.D. | Suite 10 21229 5411 Old Frederick Road, Baltimore, MD. | | MAR 10 1987 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | 23e. REGISTRAR'S SIGNATURE | |
| BURIAL | 3/11/87 | CRESTLAWN | MARRIOTTSTVILLE MARYLAND | | |
| 24. FUNERAL DIRECTOR | | | | | |
| Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card of payment, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certificate promptly. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 07448 | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Edgar Samuel Hubbard Sr | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-17-87 | |
| 3. SEX
Male | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
1 16 18 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND HOSP | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Marriottsville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY C. HUBBARD | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE E. SAMM | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
Yes WW 2 | | 16b. SOCIAL SECURITY NO.
213-07-6610 | | 17. INFORMANT ADDRESS
Mrs. M. Eleanor Hubbard MD 21104 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>acute non-lymphocytic leukemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/29/87</u> , 19____, to <u>3/17/87</u> , 19____, that (I) (we) lost saw the deceased alive on <u>3/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Achakra V. Arthy</u> | | DEGREE | | 22c. DATE SIGNED
3-17-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>CHAKRAVARTHY</u> | | 22e. ADDRESS
<u>22. S. GREENE</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-21-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Memorial Pk | |
| 24. FUNERAL DIRECTOR NAME
Loring Byers Funeral Directors, Inc | | 25a. DATE REC'D. BY REGISTRAR
MAR 19 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Eldersburg Carroll MD | | 23e. ADDRESS
8728 Liberty Rd. Randallstown, MD 21133 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|---|--|------------------------------------|---|---|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | 87 | | REG. NO. 07449 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR P M | | |
| BABY BOY HUDSON | | | | | | MARCH 20, 1987 | | | 2:49 P M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| MALE | | BLACK | | 03 - 20 - 87 | | | | | | 2 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| MARYLAND | | | Baltimore | | | BALTIMORE | | | 13e. STREET ADDRESS / ZIP CODE RTE.3 BOX 470.BERLIN, MD.21811 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| JESSE JONES | | | CYNTHIA HUDSON | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| | | | | | | CYNTHIA HUDSON. (SAME AS ABOVE) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Immature lungs</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prenaturity</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 minute</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> , 19 <u>87</u> , to <u>3/20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2:47 3/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Linda Solow</u> DEGREE | | | | | | 22c. DATE SIGNED <u>3/21/87</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Linda Solow</u> | | | | | | 22e. ADDRESS <u>600 N. WOLFE ST. BALTO., MD 21205</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| CREMATION | | | 3-23-87 | | JOHNS HOPKINS HOSPITAL | | BALTIMORE, MD.21205 | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| JOHNS HOPKINS HOSPITAL. 601 N. WOLFE ST | | | | | | MAR 30 1987 | | | <u>Julia Dickinson-Rodgers</u> | | |

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COMMUNICATIONS SECTION

8 1 0 1 1

MAR 30 1981

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/B4
(VRA 15, 4)

| | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|---|--|--|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
| REG. NO. 87 07450 | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CHARLES HERBERT HUFNAGEL JR. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 26 87
2b. HOUR
8:30 AM | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 22 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57
YRS. MONTHS DAYS HOURS MIN. | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS | | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MGR. | | 12b. KIND OF BUSINESS OR INDUSTRY
CHESSIE SYST. | | | |
| 13a. STATE
MD. | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
CATONSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
327 WESSLING CIRCLE 21228 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES HERBERT HUFNAGEL SR. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET STROMBERG | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-28-6427 | | 17. INFORMANT
MARK E. HUFNAGEL | | ADDRESS
1003 2C SCARLETT OAK CT.
HAMPSTEAD, MARYLAND 21074 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG WITH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) WIDESPREAD METASTASES.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
James E. Taylor | | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/26/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES E. TAYLOR, M.D. | | | | | 22e. ADDRESS
ST. AGNES HOSPITAL, BALTIMORE, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
3/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WOODLAWN MARYLAND | | | | |
| 24. FUNERAL DIRECTOR
LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A.
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | | | 25a. DATE REG'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to its burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified at (410) 327-1100.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | 87 | | REG. NO. 07451 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | | |
| Lena Burton Hughes | | | | 03 01 87 | | 8:45P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| F | | W | | 04 19 1897 | | 89 | | YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | St. Agnes Hospital | | Secretary | | Building & Loan | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | | | Baltimore | | | | 4715 Amberley Avenue, 21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| George T. Hughes | | Elizabeth Burton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 214-01-1983 | | Elsie H. McKelvy, 4715 Amberley Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | cerebral ischemia | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | DUE TO, OR AS A CONSEQUENCE OF (b) cardiovascular insufficiency | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| A. Maciulis MD | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| A. MACIULIS | | St. Agnes Hospital, 900 S. Caton Avenue | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 3/4/87 | | Woodlawn Cemetery | | Woodlawn Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hubbard Funeral Home, Inc. | | 4107 Wilkens Ave. | | MAR 04 1987 | | Lia Swenson-Randall | | | |

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Handwritten text, possibly a signature or name, appearing in the center of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, page 3, to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07452 | |
|---|--|---|--|---|---|---|--|---|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Thomas Hughes | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 3 1987 | | | 2b. HOUR
M | | | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 1 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1939 Pennsylvania Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1939 Penna Avenue 21217 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Chadrack Hughes | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | | | 16b. SOCIAL SECURITY NO.
212-20-2470 | | 17. INFORMANT
ADDRESS
Regina Walker 1939 Penna Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic recurrent esophageal cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cadexia</u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
<u>none</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2/26/87</u> 19 <u>87</u> to <u>2/26/87</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>2/26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not see the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Nicholas B Argento</u> | | | | DEGREE | | 22c. DATE SIGNED
3/5/87 | | 22d. ADDRESS
22 Screene Street Balt, MD 21201 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Nicholas B Argento MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/6/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 06 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed page 3 from this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified on page 4.

DHMH - 16 60M 7/B4
(VRA 15, 4)FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07453

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William T. Humphreys | | | | 2a. DATE OF DEATH MONTH 3 DAY 6 YEAR 87 2b. HOUR 3:00A | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 04 DAY 08 YEAR 92 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER | |
| 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | 13a. STATE MARYLAND 13b. COUNTY -- 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME FIRST JOSHUA MIDDLE T. LAST HUMPHREYS | | | | 15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220-01-4795 | | 17. INFORMANT MARY MARSHALL | | ADDRESS SAME AS # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) URINARY TRACT INFECTION | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE RECTUM | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH 12 DAY 19 YEAR 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 12 19 87 to MARCH 6 19 87 , that (I) (we) lost saw the deceased alive on MARCH 8 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Oscar C. Munde, M.D. DEGREE M.D. | | | | 22c. DATE SIGNED 6 March 1987 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oscar C. Munde M.D. | |
| 22e. ADDRESS St. Agnes Hospital, Baltimore, MD. | | | | 22f. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 3/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville MARYLAND | |
| 24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE ADDRESS 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

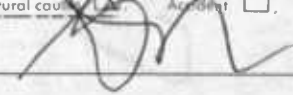

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4

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **7 4 5 4**

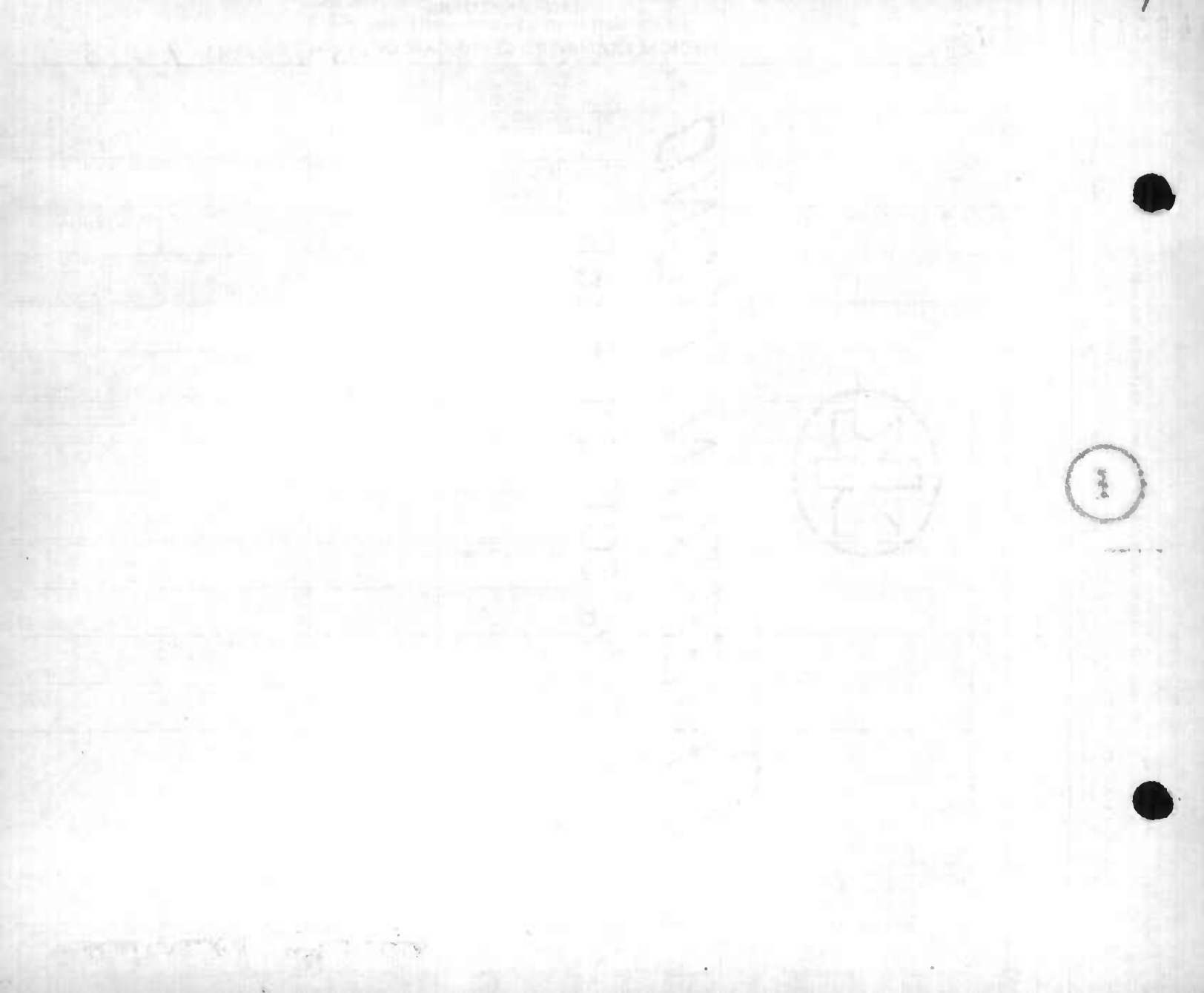
| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Eva Hunt | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3/ 4/ 19 87 | | 2b. HOUR M | |
| 3. SEX feamle | | 4. RACE black | | 5. DATE OF BIRTH
MONTH DAY YEAR 5 21 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 3/ 4/ 1987 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1032 W. Franklin St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 121223 1032 W. FRANKLIN ST. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST EUGENE MCCULLOH | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST MATTIE JOHNSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 218305411 | | 17. INFORMANT ADDRESS WILMA BROWN 1032 W. FRANKLIN ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 3/4/87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 3/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE BALTO MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue | | | | 25a. DATE RECEIVED BY REGISTRAR MAR 06 1987 | | 25b. REGISTRAR'S SIGNATURE  | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the placards. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>JOHN H. HUNT, SR.</u> | | | 2a. DATE OF DEATH
MONTH <u>02</u> DAY <u>13</u> YEAR <u>1987</u> | | | 2b. HOUR
<u>1545</u> M | | | | | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>WHITE</u> | | 5. DATE OF BIRTH
MONTH <u>11</u> DAY <u>23</u> YEAR <u>1919</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>67</u> YRS | | 7. IF UNDER 2 YEAR
MONTHS <u></u> DAYS <u></u> | | 8. IF UNDER 24 HRS
HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<u>Illinois</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Memorial University Hosp.</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS)
<u>Retired Lt. Col.</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>U.S.A.F.</u> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>MD</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Monkton</u> | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>612 CORBETT RD 21111</u> | | | |
| 14. FATHER'S NAME
FIRST <u>Martin</u> MIDDLE <u>Luther</u> LAST <u>Hunt</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Lizzie</u> MIDDLE <u>Mae</u> LAST <u>Malone</u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>Yes</u> | | 16b. SOCIAL SECURITY NO.
<u>344-03-0343</u> | | 17. INFORMANT
ADDRESS
<u>Stephen T. Hunt - same as #13e</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
<u>8/199 MULTIPLE INJURIES WITH</u>
IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u>
DUE TO, OR AS A CONSEQUENCE OF <u>COMPLICATIONS</u>
(b) <u>adult respiratory distress syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>ACCIDENT</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>1/23/87</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 1 23 87</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
<u>motor vehicle accident</u> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u>Street</u> | | 21f. LOCATION
STREET <u>York Road & Belfast, Balto. Co., Maryland</u>
CITY OR TOWN <u>Balto.</u> COUNTY <u>Balto.</u> STATE <u>Md.</u> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 23 1987</u> to <u>Feb 13 1987</u> , that (I) (we) last saw the deceased alive on <u>Feb 13 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Anthony L. Buchanan</u> | | DEGREE <u>MD</u>
CERTIFICATION APPROVED BY MEDICAL EXAMINER
PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>
<u>Feb 13 1987</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Anthony L. Buchanan</u> | | 22e. ADDRESS
<u>225 Greene Street Baltimore, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Cremation</u> | | 23b. DATE
<u>2-17-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Westview Crematory</u> | | 23d. LOCATION
CITY OR TOWN <u>Balto.</u> COUNTY <u>Balto.</u> STATE <u>Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Ruck Towson Funeral Home, Inc.</u> | | ADDRESS
<u>1050 York Rd. Towson, Md. 21204</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 19 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Darden</u> | | | | | |

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07456

| | | | |
|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Christine | | 2. DATE KNOWN OF DEATH
MARCH 11 1987 | |
| 3. SEX
Female | | 4. RACE
Black | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
8 05 1920 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 8. CITY OR TOWN OF DEATH
Baltimore | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, | |
| 10. USUAL RESIDENCE (IF IN PRISON, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
NEW YORK | | 13b. CITY OR TOWN
Brooklyn | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susie Patterson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No. | | 16b. SOCIAL SECURITY NO.
225-26-2020 | |
| 17. INFORMANT
Jones Hunter | | ADDRESS
80 Halsey Street Brooklyn N. Y. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8199 IMMEDIATE CAUSE (a) Blunt Trauma of Head
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerotic Hypertensive Cardiovascular Disease | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
Primary | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
7:00 P.M. 3 10 1987 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject's head struck windshield in auto impact. | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
roadway | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Baltimore, Maryland
BWI & I-95 Cut Off to City | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
Gregory R. Kauffman, M.D. | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | DATE
3/11/87 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/18 /1987 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LINDEN, NEW JERSEY | |
| 24. FUNERAL DIRECTOR NAME
NUMER & SONS FUNERAL HOME, INC. | | 25a. DATE REC'D BY REGISTRAR
MAR 18 1987 | |
| 25b. REGISTRAR'S SIGNATURE
2501 Gwynns Falls Pkwy, Baltimore, Md. 21216 | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE FOLLOWING SPACES: 1. AND 2. AND 3. TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL, TRANSFERRAL, OR CREMATION PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.


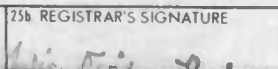
DHMH - 17
(VR A15 ME (5))



048203 MAR 26 07

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 87 7 4 5 1 | |
|---|--|----------------------|---|---|------------------------------------|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Emil Iczkovicz | | | | | | 2a. DATE KNOWN OF DEATH 3/15/87 | | 2b. MONTH 3 DAY 15 YEAR 87 | | 2c. HOUR 10 | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH FEB. 14, 1908 | | 6. AGE (IN YEARS) 79 | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | 2d. DATE PRONOUNCED DEAD 3/15/87 | |
| 7a. BIRTHPLACE (STATE OR CITY AND COUNTY) CZECHOSLOVAKIA | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3702 Glen Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MAINTENANCE OF LIFE) LABORER | | | 12b. KIND OF BUSINESS BUILDING | |
| 11a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND DOOR NO. 3702 GLEN AVE. #21215 | | |
| 14. FATHER'S NAME UNOBTAINABLE | | | | | | 15. MOTHER'S MAIDEN NAME UNOBTAINABLE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 217-34-9710 | | 17. INFORMANT RICHARD A. FRIEDLANDER
9 W. MULBERRY ST. BALTO., MD 21201 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 3/16/87 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE MAR. 18, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW | | | 23d. LOCATION BALTIMORE COUNTY MARYLAND | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 24 1987 | | 25b. REGISTRAR'S SIGNATURE  | | | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

30% COTTON FIBER

MADE IN U.S.A.

DOWN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

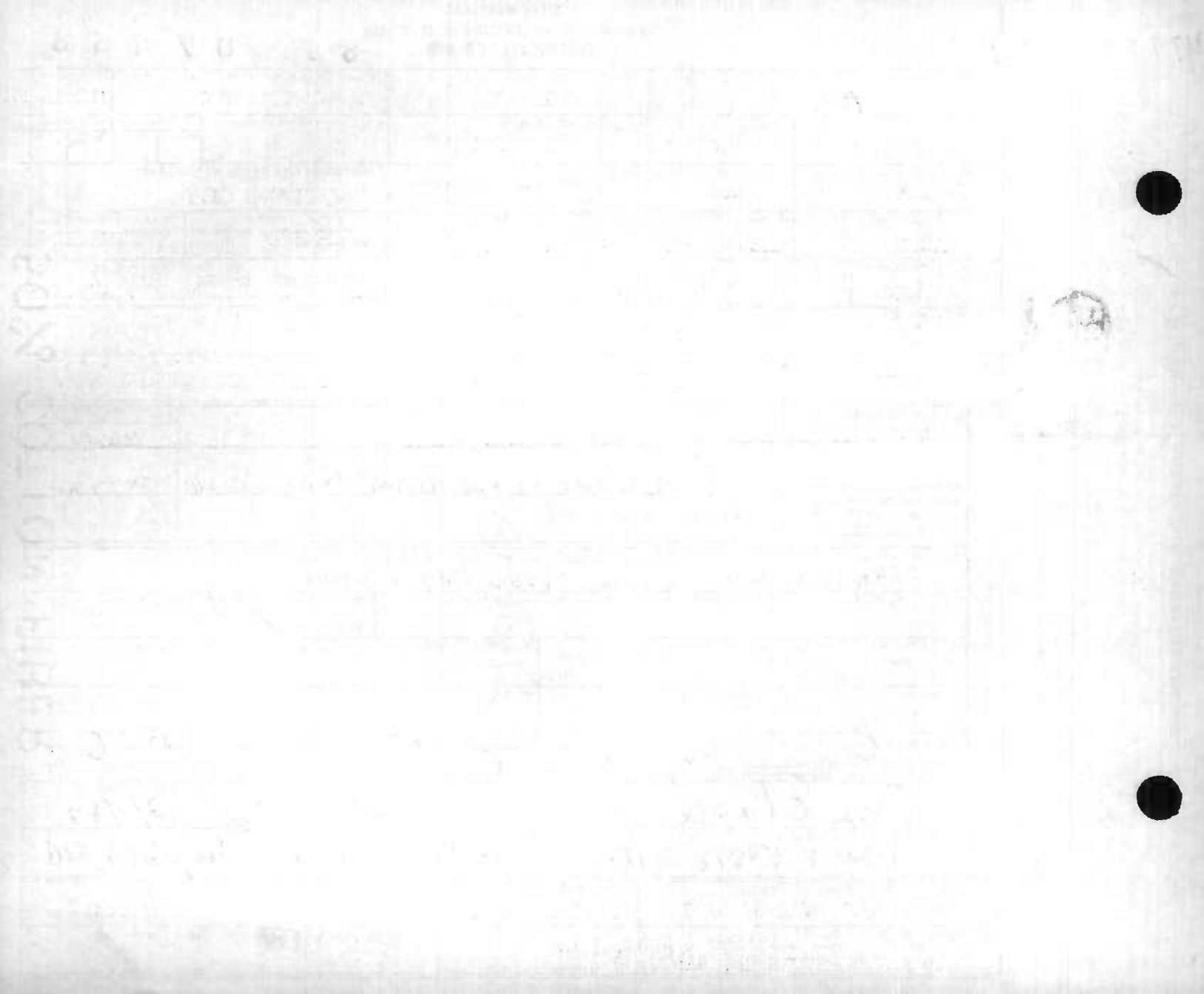
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07458

| | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---------------------------------------|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ADA | | | MIDDLE IDELSON | | | LAST IDELSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 11, 1987 | | | 2b. HOUR
12:15 M | | |
| 3. SEX
FEMALE | | | 4. RACE
CAUCASIAN | | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 15, 1894 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS | | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MICHIGAN | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6310 GREENSPRING AVE., APT. T5 | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OF WORKING LIFE)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY
HOMEMAKER | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6310 GREENSPRING AVE., APT. T5 (21209) | | |
| 14. FATHER'S NAME
ELI MIDDLE ATLIVAICK | | | | | | 15. MOTHER'S MAIDEN NAME
GETEL MIDDLE COPAL | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | | 16b. SOCIAL SECURITY NO.
213-74-0265 | | | 17. INFORMANT ADDRESS
MICHAEL IDELSON 6310 GREENSPRING AVE. APT. T-5 (21209) | | | | | |

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Minutes | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction + Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | 30 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Osteoporosis, severe; Necrotic urinary tract in lobes | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (if this hospital) attended the deceased from Feb 65 , to 3/11 , 19 87 , that (I) (we) last saw the deceased alive on Feb 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Leon E. Kasel | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEON E. KASSEL, MD | | | | | | 22e. ADDRESS
2435 W. Belvedere Ave, Balto, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL/REMOVAL | | | 23b. DATE
3/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY
EMANUEL CEM. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DENVER COLORADO | | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | | | 25a. DATE RECEIVED BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |

BP

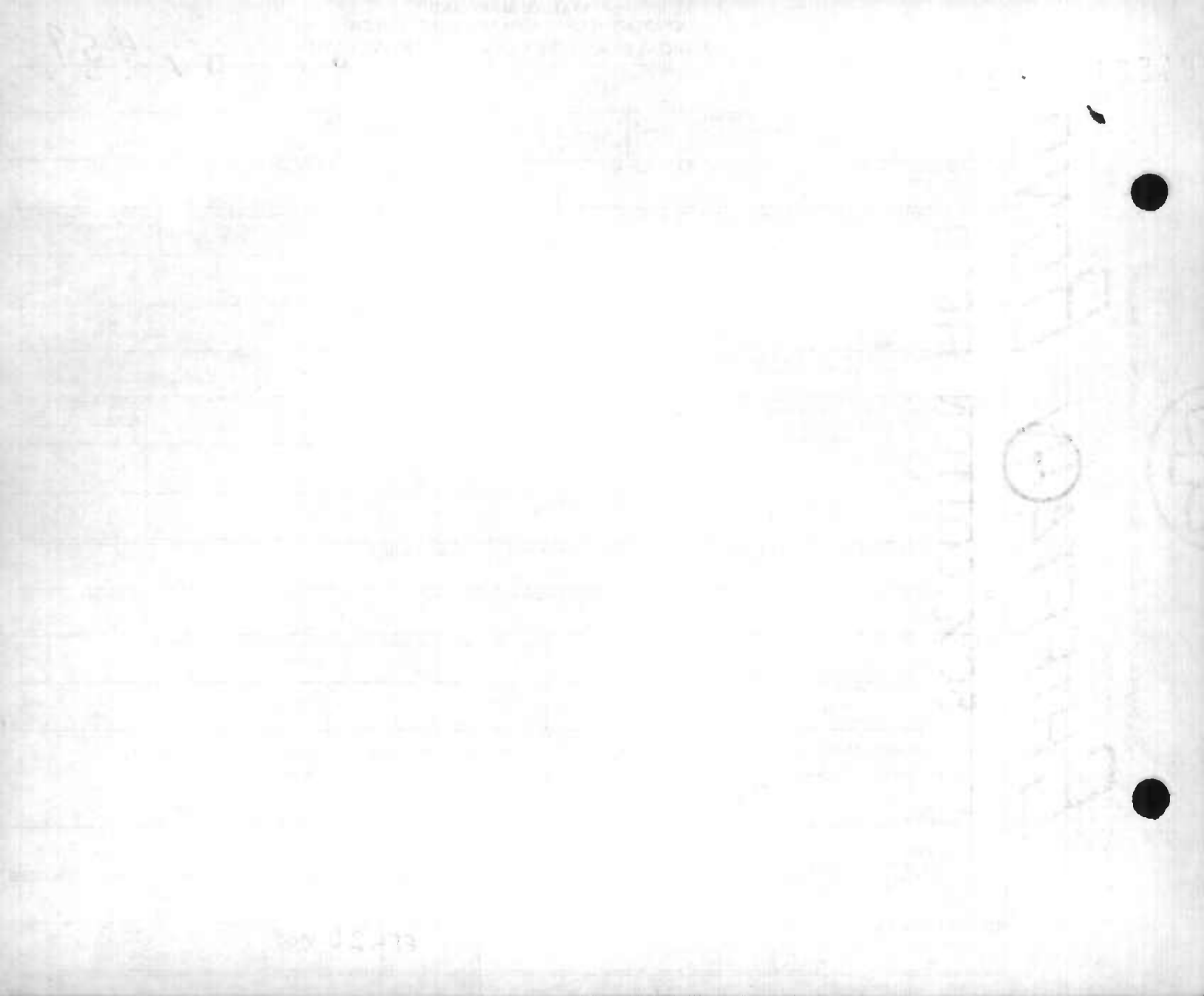


459

| | | | | | | | | | | |
|--|---------|---|--------------------------------------|---|---|--------------------------------------|---|-----------------------------------|--|--|
| DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | DATE KNOWN OF DEATH ESTI- MATED | | MONTH | DAY | YEAR | HOUR |
| ROBERT | | Lewis | | INGRAM | | | 2 | 21 | 19 | 87 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD | MONTH | DAY | YEAR | 2d. HOUR |
| Male | Black | 6/9/48 | 38 | | | DEAD | 2 | 21 | 19 | 87 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Winston Salem NC. | | USA | | | | Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Liberty Medical Center | | | Cloverland Dairy | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| 13a. STATE | | | | | | 216 Springhill Ave. 21215 | | | | |
| Maryland | | | | | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | LAST | | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | LAST | | |
| Robert | | L. | Richardson | | Jessie | | Ingram | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | 242-78-6424 | | Jeannette Ingram 3904 Reisterstown Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
<u>8909</u> IMMEDIATE CAUSE (a) <u>Hypertrophic Cardiomyopathy</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | 20 AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2 21 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Subject collapsed after Housefire. | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
2616 Springhill Avenue Balto.City,Md. | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | DATE SIGNED 2-22-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | |
| Gregory R. Kauffman, M.D. | | 111 Penn St., Balto., MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SEEPY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 2/28/87 | | Evergreen Cem. | | | Winston Salem NC. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| March F/H West 4300 Wabash Ave. | | | | | FEB 26 1987 | | Julia [Signature] | | | |

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



048667 MAR 31

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 1 07460
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BISHOP Fancher, Ivery | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 27 87 | | 2b. HOUR
0619A | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 20 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Minister | | 12b. KIND OF BUSINESS OR INDUSTRY
PASTOR | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTO. | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4017 CHATHAM RD. 21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PERRY FANCHER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY FANCHER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT ADDRESS
190-12-6288 ALTHEA FANCHER 4017 CHATHAM RD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
0545-0619 | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Coronary Disease, Renal Failure | | | | | | | |
| 19a. DATE OF OPERATION
3/20/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Left Knee Arthritis | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3/20 87 to 3/27 87 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/20 87 to 3/27 87 , that (I) (we) lost
saw the deceased alive on 3/27 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Peter Loeb | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter Loeb, M.D. | | 22e. ADDRESS
1 East University Parkway #204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/31/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILL, MARYLAND | |
| 24. FUNERAL DIRECTOR
LEROY O. DYETT 4600 LIBERTY HEIGHTS | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
Julie Anderson-Rodale | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

10-11-68

RECEIVED

10-11-68

3085 COLTON HIGH

WINTERHILL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place the certificate in the container for the body. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07462 | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
IRENE M. JACKSON | | | 2a. DATE OF DEATH MONTH 3 DAY 21 YEAR 1987 HOUR 1:30 P.M. | | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPTEMBER 27, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
HUNGARY | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
MARYLAND BALTIMORE | | 13b. CITY OR TOWN
CATONSVILLE | | 13c. STREET ADDRESS / ZIP CODE
210 INGLESIDE AVENUE 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD TRATTNER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARIE UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-10-6026 | | 17. INFORMANT ADDRESS
FREDERICK JACKSON SAME AS # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>sudden death</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
0
5 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10
<u>① Diabetes mellitus ② Status post CVA & a mild myocardial infarction</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>June 27, 1983</u> to <u>March 21, 1987</u> that (1) (we) lost saw the deceased alive on <u>March 21, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>DAMIAN E. BIRCHES</u> MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>MARCH 21, 1987</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAMIAN E. BIRCHES MD | | 22e. ADDRESS
<u>5411 OLD FREDERICK RD, SUITE 10</u>
<u>CATONSVILLE, MARYLAND. 21229</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MOST HOLY REDEEMER | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
<u>MAR 23 1987</u> <u>Julia Friedman-Pulley</u> | | | |
| 24. FUNERAL DIRECTOR
LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A.
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | | | |

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 87 07463 | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Rev. Kelly | | L. | | Jackson | | | | 3 12 87 | | M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Male | | Black | | 5 31 1898 | | 88 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| N. Carolina | | U. S. A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | 3300 Hillside Road | | Ret. Minister. | | Methodist Ch | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | | | Baltimore | | | | Maryland 21207 3300 Hillside Road Baltimore | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Andrew Jackson | | Martha Jane Pegrahm | | | | | | | | | |
| 16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | |
| No. | | 216-36-9236 | | Mrs. Elaine C. Fields | | Baltimore, Md. 3300 Hillside Rd. 21207 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE WITH LUNG METASTASIS (b) MYOCARDIAL INFARCTION (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/7 1975, to 3/12 1987, that (I) (we) last saw the deceased alive on 3/12 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE KEIFFER J. MITCHELL MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 3/16/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEIFFER J. MITCHELL | | | | | | 22e. ADDRESS 1230 DROID HILL AVE. BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | | | |
| Burial | | 3/17/1987 | | Evergreen Cemetery | | Berlin | | Maryland | | | |
| 24 FUNERAL DIRECTOR'S NAME AND ADDRESS | | | | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Nutter & Sons Funeral Home, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | | | MAR 18 1987 | | [Signature] | | | |

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RELEASED NON MED DR WM ZANE PER MR. LAWYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|--|-----------------------------|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MAMIE M. JACKSON | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 6, 1987 | | | 2b. HOUR
7:32A M | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 2 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMP. | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HUEY HALL | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MATTIE GEE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
251621922 | | 17. INFORMANT
ADDRESS
MATTIE L. HESTER 2533 E. OLIVER ST. 21213 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>ONE HOUR</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION
_____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
_____ | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
_____ | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
_____ | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 6, 1987</u> to <u>March 6, 1987</u> , that (I) (we) last saw the deceased alive on <u>March 6, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert A. Luke MD</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/6/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT A. LUKE, MD | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL, BALTIMORE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | | | | |

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07465

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
NORMAN A. JACKSON | | 2a. DATE OF DEATH MONTH DAY YEAR
03 29 87 | | 2b. HOUR
4PM M | |
| 3. SEX
Male | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
12 25 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GEORGIA | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital of Baltimore | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CHAPLAIN. | | 12b. KIND OF INDUSTRY
BALTO. RESCUE MISSION | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NORMAN A. JACKSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALICE RAWLINS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | |
| 17. INFORMANT
BALTIMORE, MD. 21215 | | 18. RUTH YOUNG | | 2451 W. COLDSRING LANE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>UNDERSERVED MALIGNANCY</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>3 months</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>3/16</u> , 19 <u>87</u> , to <u>3/29</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/25</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Frederick H. Henson</u> | | DEGREE <u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<u>4/1/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FRED HENSON MD | | 22e. ADDRESS
MEDICAL CENTER 601 N. WOLF STREET BALTIMORE MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
4/4/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST VETERANS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
NUTTER & SONS FUNERAL HOME, INC.
2501 Gwynns Falls Pkwy, BALTIMORE, MD, 21216 | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 6 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rudolph | |

BP

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047409

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS FORM IS TO BE FILED WITH THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS FORM. PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 07466

| | | | | | | | |
|---|---|---|--|---|--------------------------------------|--|--|
| FOR
1. STATE
REGISTRAR | | 2a. DATE KNOWN OF DEATH ESTIMATED | | 3. MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 3. MONTH DAY YEAR | | 2b. HOUR | |
| WILLIAM JACKSON | | 3. MONTH DAY YEAR | | 3. MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 2d. HOUR |
| M | 3 | 9 13 80 | 6 YRS. | | | 3 13 1987 | 6:12 P.M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| BALTO MD | USA | | | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | Johns Hopkins Hospital | | Student for 50 years | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | | | |
| MD | | BALTIMORE | | 510 N. Gilman St 21223 | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 17. INFORMANT ADDRESS | | | |
| Roy Watson | | Karen Green | | Mary A Green 510 N. Gilman St | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8141 IMMEDIATE CAUSE (a) Cranio-cerebral trauma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | | 1:15 P.M. 3-4-1987 | | Pedestrian struck by auto. | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | street | | Gilmore St. at, Balto. City | | MD | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | |
| William M. Zane, M.D. | | Assistant | | 3-14-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn St., Balto., MD | | 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 3/15/87 | | Mt. Vernon | | BALTO MD 21230 | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Mary Ann D. Long | | 630 N. Gilman St | | MAR 17 1987 | | Lisa Davidson-Pandick | |

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46452 MAR 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called for an autopsy.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07467

| | | | | |
|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) DOLAKES M. JACOBS | | | 2a. DATE OF DEATH
MONTH 3 DAY 5 YEAR 87 2b. HOUR 9:24 P | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH 05 DAY 26 YEAR 02 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
84 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Balto. Gen. Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | 13b. COUNTY
----- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST JOSEPH MIDDLE P. LAST FLEBURGER | | 15. MOTHER'S MAIDEN NAME
FIRST CATHERINE MIDDLE --- LAST TIERNEY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
215-01-4008 | | 17. INFORMANT
ADDRESS
Mr Edward J. Fleburger, same as above |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Embolism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Gerard M. Londer | | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/5/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GERARD M. LONDER MD | | 22e. ADDRESS
321 E. MAPLE ROAD/LINTHICUM, MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
3/9/1987 | 23c. NAME OF CEMETERY OR CREMATORY
cedar will cemt. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. A.A.CO. MD. 21090 |
| 24. FUNERAL DIRECTOR
NAME BALTO. MD. 21230 ADDRESS McGully funeral home, 130 E. Port Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 09 1987 | | 25b. REGISTRAR'S SIGNATURE |

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death and returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial's death permit. Then please remove the certificate from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
IRVIN M. JACOBSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 26, 1987 | | | 2b. HOUR
P
11:05 M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
JAN. 2, 1920 YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7b. HOUR
P
11:05 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(WORK OR TASK, INDUSTRY OR SERVICE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
FURNITURE | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY BALTO 13c. CITY BALTIMORE | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JULIUS J. JACOBSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE KROOP | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
YES NO OR UNKNOWN
YES | | | 16b. SOCIAL SECURITY NO.
216-03-5344 | | 17. INFORMANT MRS. FLORINE JACOBSON APT. E
6600 SANZO RD. BALTO., MD 21209 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCTION
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 DAYS
9 DAYS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
3/18/87 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
MYOCARDIAL INFARCTION | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 18, 1987, to MARCH 26, 1987, that (I) (we) last saw the deceased alive on MARCH 26, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E. S. J. WANG | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/26/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. S. J. WANG | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL, BALTO MD 21205 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
MAR. 29, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
PROGRESSIVE RUDOMER VEREIN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO. MD | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | |

102 28 255 E
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M 11/11/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

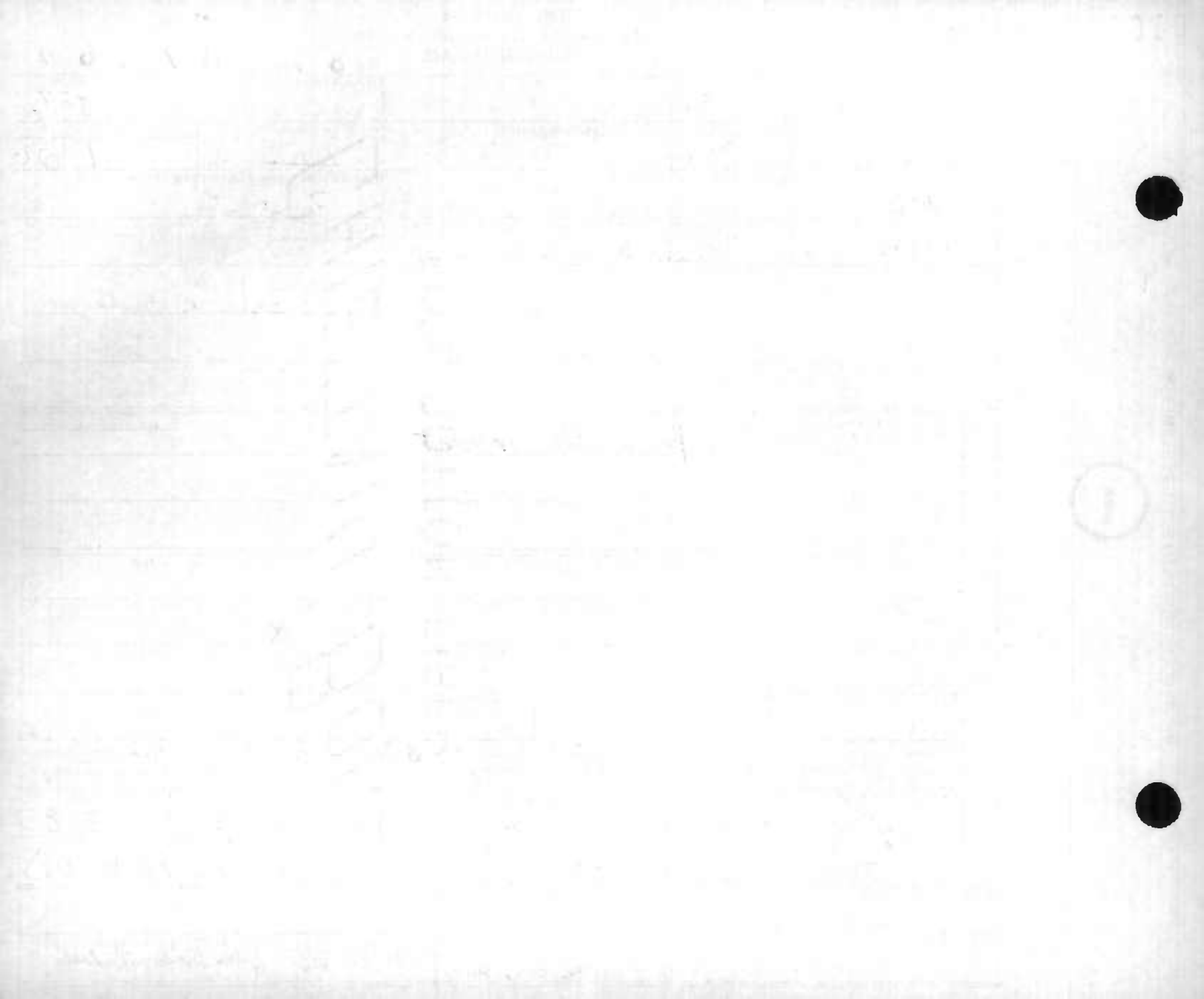
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07469 | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>male James</u> | | | | 2a. DATE OF DEATH
MONTH <u>3</u> DAY <u>3</u> YEAR <u>87</u> 2b. HOUR <u>527</u> PM | | | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>Black</u> | | 5. DATE OF BIRTH
MONTH <u>3</u> DAY <u>3</u> YEAR <u>87</u> | | 6. AGE (IN YEARS (LAST BIRTHDAY))
<u>16</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MD.</u> | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Balt City</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Balt.</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>South Balt. Gen. Hosp.</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>md.</u> 13b. COUNTY <u>Balto</u> 13c. CITY OR TOWN <u>Balto</u> | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>422 Swale Rd. 21225</u> | |
| 14. FATHER'S NAME
FIRST <u>Augustus</u> MIDDLE <u>-</u> LAST <u>Bullock Jr.</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Monica</u> MIDDLE <u>Sonia</u> LAST <u>James.</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Previae infant</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>-</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>3-3</u> 19 <u>87</u> to <u>3-3</u> 19 <u>87</u> that (1) (we) lost
saw the deceased alive on <u>3-3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) <u>view the body after death.</u> | | | | | | | |
| 22b. SIGNATURE
<u>Judith L. Chipchin</u> | | 22c. DATE SIGNED
<u>3-3-87</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JUDITH L. CHIPCHIN</u> | | 22e. ADDRESS
<u>3001 S. Hanover St. Balto., MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Removal</u> | | 23b. DATE
<u>3-5-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME <u>Anatomy Board</u> ADDRESS <u>Balto., Md.</u> | | | | 25. DATE REC'D. BY REGISTRAR
<u>MAR 09 1987</u> | | 26. REGISTRAR'S SIGNATURE
<u>Julia Gordon-Rudolph</u> | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and keep page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Michael A. James | | | 20. DATE OF DEATH
MONTH DAY YEAR
3 15 87 | | | 2b. HOUR
12 ⁰⁰ AM | |
| 3. SEX
M | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 27 58 | | 6. AGE (IN YEARS LAST BIRTHDAY)
28
YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | |
| 10. CITY OR TOWN OF DEATH
Balt. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Federal Express | |
| 13a. STATE
MD | | 13b. COUNTY
Balt. | | 13c. CITY OR TOWN
Balt. City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alfred R. James | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Parran | | 13e. STREET ADDRESS / ZIP CODE
14B1 Warren PK Dr. 21208 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-80-4549 | | 17. INFORMANT
Tanya James | | ADDRESS
14B1 Warren PK Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cordiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13, 19 87, to 3/15, 19 87, that (I) (we) last saw the deceased alive on 3/14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] 9008 | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Barry Wertheimer | | | | 22e. ADDRESS
5847 B Western Run Dr. Balt. MD 21209 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Md. | |
| 24. FUNERAL DIRECTOR'S NAME
Wm C March F/H West 4300 Wabash Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP

48670 MAR 31 1987

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07471

| | | | | | |
|---|--------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George James | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/27/87 | | 2b. HOUR
11:21 AM | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
6/9/29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Towson, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MD | | 13b. COUNTY
Balto. | | 13c. STREET ADDRESS / ZIP CODE
1217 Havenwood Ct. 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH JAMES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VIVIAN JAMES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
n/a | | 17. INFORMANT ADDRESS
JILL P. JAMES 3308 HILTON ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Exsanguination</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured aortic Aneurism</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION
3/27/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ruptured aortic Aneurism | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3/27</u> , 19 <u>87</u> , to <u>3/27</u> , 19 <u>87</u> , that (I) (we) just saw the deceased alive on <u>3/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Steve Harrison</u> | | DEGREE
(M.D.) | | 22c. DATE SIGNED
3/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steve Harrison, M.D. | | 22e. ADDRESS
Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/1/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Rest | |
| 24. FUNERAL DIRECTOR
LEROY O. DYETT | | 4600 LIBERTY HEIGHTS | | 25a. DATE RECD. BY REGISTRAR
MAR 30 1987 | |

25b. DATE RECD. BY REGISTRAR
MAR 30 1987

25c. DATE RECD. BY REGISTRAR
MAR 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



20% COTTON FIBER



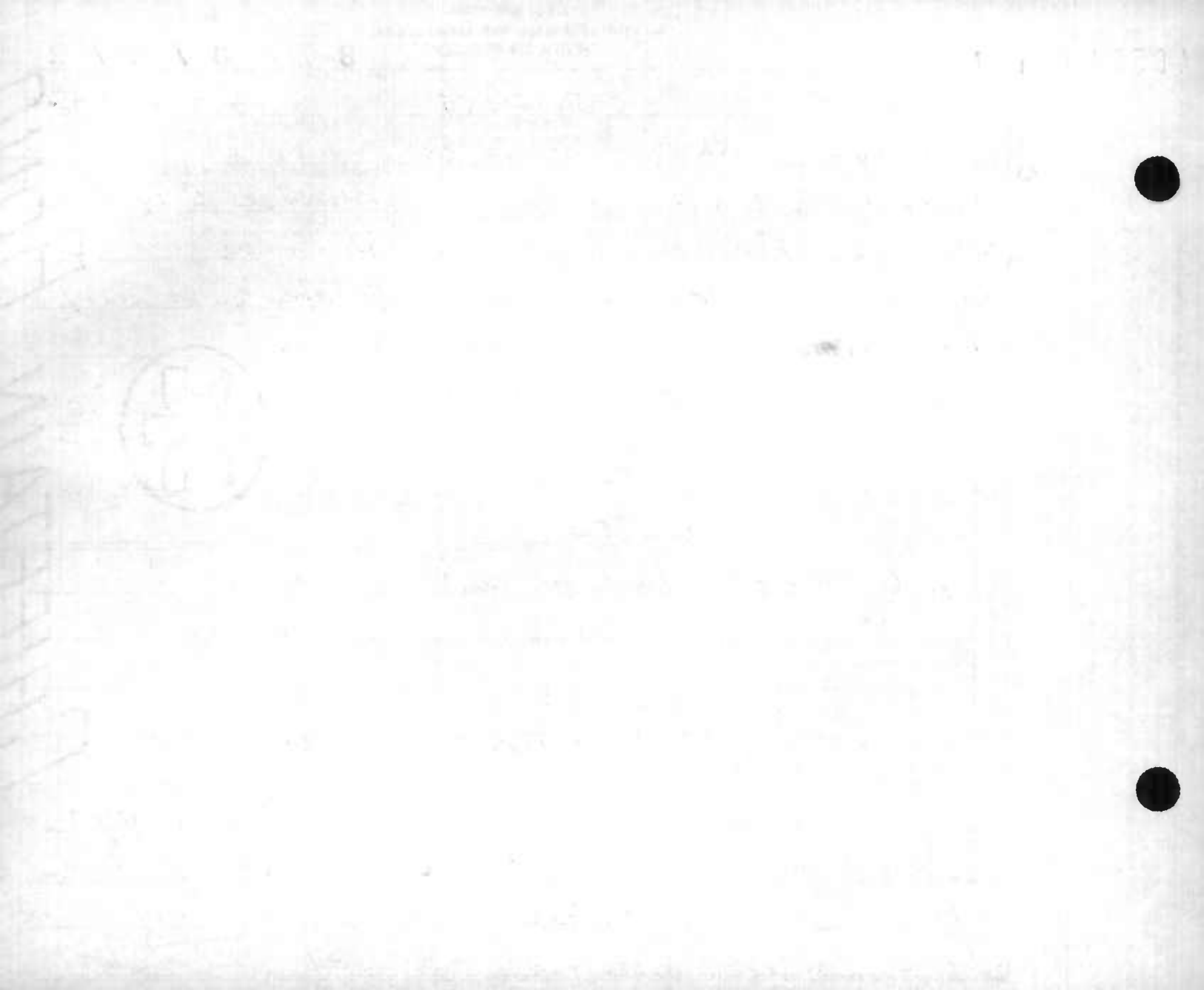
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07472 | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALICE JARRETT | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 3 7 '87 2b. HOUR 945PM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR 02 22 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MED CEN | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
HOUSEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tom Easton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JENNIE JACKSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
279160502 | | 17. INFORMANT ADDRESS
Mrs. E. A. Williams 700 N. Appleton St 21214 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration of tube feedings
DUE TO, OR AS A CONSEQUENCE OF (c) Dementia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs
24 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Malnutrition, atherosclerotic peripheral vascular disease | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 7/14/82 (1982) to 3/7 19 '87 , that (1) <input checked="" type="checkbox"/> (we) lost now the deceased along as B-7 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) <input checked="" type="checkbox"/> (did) did not visit the body after death. | | | | | | | |
| 22b. SIGNATURE
Melvin Hector | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Melvin Hector | | 22e. ADDRESS
40 Francis Scott Key Med Ctr Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
3-14-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | |
| 24. FUNERAL DIRECTOR
NAME 65424 L. Ruse 3222 W. NORTH AVE ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR MAR 10 1987 REGISTRAR'S SIGNATURE John Gordon Baker | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07473

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| FOR
STATE
REGISTRAR | | 1a DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
Russell Jarvis | | 2a DATE OF DEATH
MONTH DAY YEAR
3 7 87 | | 2b HOUR
1135A ^M | |
| 3. SEX
M | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 18 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven VA Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY
Farming | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE CITY OR TOWN
Md. Balto. Reisterstown | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
17 Westminister Rd. 21136 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Hawley Jarvis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Kegelly | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | 16b. SOCIAL SECURITY NO.
407-10-9184 | | 17. INFORMANT
ADDRESS
Darlene Ayres 10725 York Rd.
Cockeysville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>hemiphsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>squamous cell carcinoma lung</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 weeks
8 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
(a) WHILE (b) WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (1) this hospital attended the deceased from 2/15 1987, to 3/7 1987, that (1) (we) lost sight of the deceased on 3/7 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) we did (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
Linda F. Barr, MD | | | | 22b. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Linda F. Barr, MD | | | | 22e. ADDRESS
Dept. of Medicine, Loch Raven VA Hosp., Balto. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
MAR. 10, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest VA | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Balto. Md | | | |
| 24. FUNERAL DIRECTOR
NAME
H. E. Ebbhardt | | | | ADDRESS
Owings Mills Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 09 1987 | | 25b. REGISTRAR'S SIGNATURE
John E. Ebbhardt | |

MEDICAL CERTIFICATION

SECTION 100

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove completed pages 1 and 2 and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | 8 7 | | 0 7 4 7 4 | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ethel G. Jefferson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 31 87 | | 2b. HOUR
6:20P M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4 30 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wesley Home, Inc. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MD | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2211 W. Rogers Avenue 21209 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Frank Harper | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dora Lee | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NA | | 16b. SOCIAL SECURITY NO.
NA 219-16-8022 | | 17. INFORMANT ADDRESS
Wesley Home, Inc. 2211 W. Rogers Balto. MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary Artery Disease, Atherosclerosis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CARRYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 27</u> , 19 <u>84</u> , to <u>March 31</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>March 30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Robert Liberto, M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>4/1/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Liberto MD | | 22e. ADDRESS
c/o Wesley Home Inc. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville, Balto. Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Burgee-Henss Funeral Home | | ADDRESS
3631 Falls Rd. | | 25a. DATE REC'D. BY REGISTRAR
APR - 3 1987 | |
| 25b. REGISTRAR'S SIGNATURE
<u>Lia Davidson-Rudner</u> | | | | | |

4/9

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87-07475
REG. NO.FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
SARAH ETHEL JENKINS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 1, 1987 | | 2b. HOUR
9:30 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
November 3, 1903 | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Orange Co., Va. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Sinai | | 12a. USUAL OCCUPATION*
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Thomas Jones | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cornelia Jane Sutherland | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No - | | 16b. SOCIAL SECURITY NO.
212 22 3554 | 17. INFORMANT
ADDRESS
Mildred Carol Miller, 2316 Smith Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Pulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cerebrovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Heart Failure</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u>
<u>2 yrs.</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<u>Chronic Obstructive Pulmonary Disease & Aortic Aneurysm</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-9-</u> 19 <u>85</u> to <u>3-1-</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>3-1-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Bernard S. Karpers, Jr.</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
MAR. 2, '87 | |
| 22d. PHYSICIAN'S NAME* (TYPE OR PRINT)
Dr. Bernard S. Karpers, Jr. | | 22e. ADDRESS
Medical Arts Bldg, Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
03-04-87 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Overlea, Balto Co., Md. |
| 24. FUNERAL DIRECTOR
NAME
Burge-Henss Funeral Home, Baltimore, Md. | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

49170 APR -307-

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07476

| | | | | |
|---|---|--|---|--|
| 1. NAME
FIRST <u>Dorothea</u> MIDDLE <u>JENNINGS</u> LAST <u>Jennings</u> | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>3/25/87</u> 3 25 87 | | 2b. HOUR
<u>11:30 P.M.</u> |
| 3. SEX
<u>Female</u> | 4. RACE
<u>Black</u> | 5. DATE OF BIRTH MONTH DAY YEAR
<u>02 3 1921</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>66</u> YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Washington, D.C.</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Balto.</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>North Charles General</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>DISAB.</u> | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
<u>MD</u> | 13b. COUNTY | 13c. CITY OR TOWN
<u>Balto.</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<u>1634 North Milton Ave.</u> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<u>James Alexander</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Fuelyn</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>228143707</u> | | 17. INFORMANT ADDRESS
<u>Cherylisa R. Jennings 2227 Aikens Ct.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic cardiomyopathy</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>pneumonia</u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/23/87</u> 19 <u>87</u> to <u>3/25/87</u> 19 <u>87</u> , that (I) (we) lost the deceased alive on <u>3/25/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
<u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3/25/87</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Dr. Nelson</u> | | 22e. ADDRESS
<u>North Charles General Hospital Baltimore MD</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | 23b. DATE
<u>3-30-87</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>King Mem. Park</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE
<u>Balto. Co. Randallstown MD.</u> | |
| 24. FUNERAL DIRECTOR NAME
<u>March Funeral Home</u> | | ADDRESS
<u>1001 E. North Ave.</u> | | 25a. DATE REC'D BY REGISTRAR
<u>MAR 27 1987</u> |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

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RECEIVED

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
|---|--|--|---|--------|---------|---|--|--|---|------|--|------------------------|--|
| Carl | | | | | Jericks | MARCH | | | 7 | 1987 | | 10:30 A.M. | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS-LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | |
| Male | | | Black White | | | MONTH DAY YEAR
3 8 08 | | | 78 YRS. | | | MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7c. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| 11. | | | U.S.A. | | | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore City | | | Union Memorial Hospital | | | Laborer | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | | |
| Md. | | | | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | |
| Unknown | | | Unknown | | | 2425 St. Paul St. 21218 | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | | |
| Yes | | | 1944 | | | 334-14-9333A Marie E. Jericks 2425 St. Paul St. 21218 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dilated cardiomyopathy</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| <u>Possible carcinoma of unknown type</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOT BY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>March 2</u> , 19 <u>87</u> , to <u>March 7</u> , 19 <u>87</u> , that (1) <input checked="" type="checkbox"/> I lost
saw the deceased alive on <u>March 7</u> , 19 <u>87</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated
above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | | | | | |
| <u>Scott Rifkin</u> | | | MD | | | 3/7/87 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | |
| Scott Rifkin | | | Union Memorial Hospital | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | |
| Cremation | | | 3-9-87 | | | Westview Memorial Park | | | Baltimore, Md. CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. SIGNATURE | | | | |
| William c. Brown 1206-08 W. North Ave. | | | | | | MAR 09 1987 | | | <u>Lisa Dendron-Randner</u> | | | | |

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the coroner's papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, entombment or reinterment.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|----------------------------|---|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARGARET V. JEWETT | | | | | 7a. DATE OF DEATH MONTH DAY YEAR 3 6 87 | | | | | 7b. HOUR 6:15 M | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR 1 23 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 2 YRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KESWICK NURSING HOME | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
REAL ESTATE BROKER | | 12b. KIND OF BUSINESS OR INDUSTRY
Ret. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13a. STATE
MD | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Baltimore | | 13e. STREET ADDRESS / ZIP CODE
100 E. Melrose Ave./21212 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Stanley Vernay | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen -- Harris | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
248-09-8033 | | 17. INFORMANT ADDRESS
Margaret H. Moseley, Washington, D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral infarction | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| CONDITIONS, IF ANY, WHICH
GAVE RISE TO IMMEDIATE
CAUSE (a), STATING THE
UNDERLYING CAUSE LAST.
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive cerebro-vascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Cerebral aneurysm left carotid artery/cerebral sinus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 11 , 19 84 , to March 6 , 19 87 , that (I) (we) lost
saw the deceased alive on March 6 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. Isabelle MacGregor MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-6-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. ISABELLE MACGREGOR | | | | | | 22e. ADDRESS
KESWICK, 700 W R 40, STREET, BALTIMORE, MD 21211 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
3/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Comfort Crem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, VA | | | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave. NW, Wash., D.C. 20016 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Gordon-Risher</i> | | | |

2130 Wisconsin Ave, NW, Wash., D.C. 20006
 Joseph Gawler's Sons, Inc.
 Cremation 3/2/87 Mt. Comfort Crem. Alexandria, VA

x

No ---
 Frank Stanley Verman Helen --
 3701 Reno Rd., NW
 Harris
 Washington, D.C.
 Margaret W. Koseley

MD -- Baltimore x 100 E. Melrose Ave. 21212

Baltimore
 White
 City
 Ref.

Margaret V. Jewett

RELEASED ON APPROVAL DR. KIRKPATRICK PER MR. LAWYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them in your files. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
BENJAMIN F. JOHNSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 28, 1987 | | | 2b. HOUR P
7:55 M | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
5/23/34 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Gen. Motors | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
505 Richwood Ave. 21212 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
BENJAMIN F. JOHNSON | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CHARLOTTE PITTS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
218-30-5058 | | 17. INFORMANT ADDRESS
DOROTHY JOHNSON 505 RICHWOOD AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC HEART DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>MOTOR VEHICLE ACCIDENT</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
40 min.
YEARS
8 DAYS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | |
| 19a. DATE OF OPERATION
3/21/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Tear; Aortic Root Bleed | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR (A.M. OR P.M.) MONTH DAY YEAR
3 P.M. 3 21 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
Motor Vehicle Accident | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
STREET | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21 to 3/28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Timothy A. Buchman MD | | | | | DEGREE
MD | | | 22c. DATE SIGNED
3/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Timothy A. Buchman | | | | | 22e. ADDRESS
600 North Wolfe Street Balto MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Owings Mills, Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Leroy O. Dyett 4600 Liberty Heights | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | | | |

BP



1774

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|--|---------------|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
CAROLINE JOHNSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 / 7 / 87 | | | | | 2b. HOUR
M |
| 3. SEX
female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
12 20 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. STATE
Maryland | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
104 N. Wheeler Ave. 21223 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Taylor | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Fannie Tillman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT ADDRESS
Coy Johnson 104 N. Wheeler Ave. 21223 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Massive Anterior MI, Cardiogenic shock, Arrhythmia Hx HTN | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 3/7 , 19 87 , to 3/7 , 19 87 , that (i) (we) lost saw the deceased alive on 3/7 , 19 87 , and that in (ii) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) (did) not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Bulent Atac | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Bulent Atac | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Pk. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR NAME
W.C. March F/H West 4300 Wabash Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Gordon-Randall</i> | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers, Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84

(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07481

| | | | | | |
|---|--|--|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
COLLIE R. JOHNSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 12, 1987 | | 2b. HOUR
MIN.
3:50 PM | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
8 27 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ARKANSAS | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOME HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BETH STEEL | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MD STATE | | 13b. COUNTY
BALTO. | 13c. STREET ADDRESS / ZIP CODE
1233 N. BOND ST. 21213 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLIE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | 16b. SOCIAL SECURITY NO.
217-09-7334 | | 17. INFORMANT
ADDRESS
ASDEAN JOHNSON 1233 N. BOND ST. 21213 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOMYOPATHY, CHF, ATN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) LIVER DISEASE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
243 hr. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)
P.M. 19 | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3/12/87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (the hospital) attended the deceased from 3/12/87 19, to 3/12/87 19, that (1) (we) last saw the deceased alive on 3/12/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I have) (I have not) view the body after death. | | | | | |
| 22b. SIGNATURE
KARASIN | | DEGREE
MD | | 22c. DATE SIGNED
3/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KARASIN, R. B. | | 22e. ADDRESS
CHURCH HOSPITAL CORP.
100 N. BROADWAY BALTIMORE, MD. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. NAT. CEMETERY LAUREL | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Denton | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07482
REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EDNA S. JOHNSON | | | 2a. DATE OF DEATH
MONTH 3 DAY 14 YEAR 1987 | | | 2b. HOUR
4:45 P.M. | | | | |
| 3. SEX
F | | 4. RACE
C. | | 5. DATE OF BIRTH
MONTH 6 DAY 17 YEAR 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3720 BOARMAN AVE 21215 | |
| 14. FATHER'S NAME
FIRST CHARLES MIDDLE LAST WILBOR | | | 15. MOTHER'S MAIDEN NAME
FIRST RACHEL MIDDLE W LAST WILLIAM | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-24-9787 | | 17. INFORMANT
husband | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Extensive metastatic lesions
DUE TO, OR AS A CONSEQUENCE OF
(b) from renal cell Ca.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19. DATE OF OPERATION
Removal of kidney & mass - renal Ca. | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR MIN. MONTH DAY YEAR 1986 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET April CITY OR TOWN 1986 COUNTY STATE | | 21g. DATE SIGNED
March 14 1987 | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 13 1987 to March 14 1987 , that (I) (we) lost
saw the deceased alive on March 13 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Alfred K. Wiedmann | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4-14-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALFRED K. WIEDMANN | | | 22e. ADDRESS
715 PARK AVE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
3/20/87 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Rest | | 23d. LOCATION
CITY OR TOWN SEVERN COUNTY Md. STATE | | | |
| 24. FUNERAL DIRECTOR
NAME ODEN GIBSON ADDRESS 1631 DRUID HILL AVE | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 and place in envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

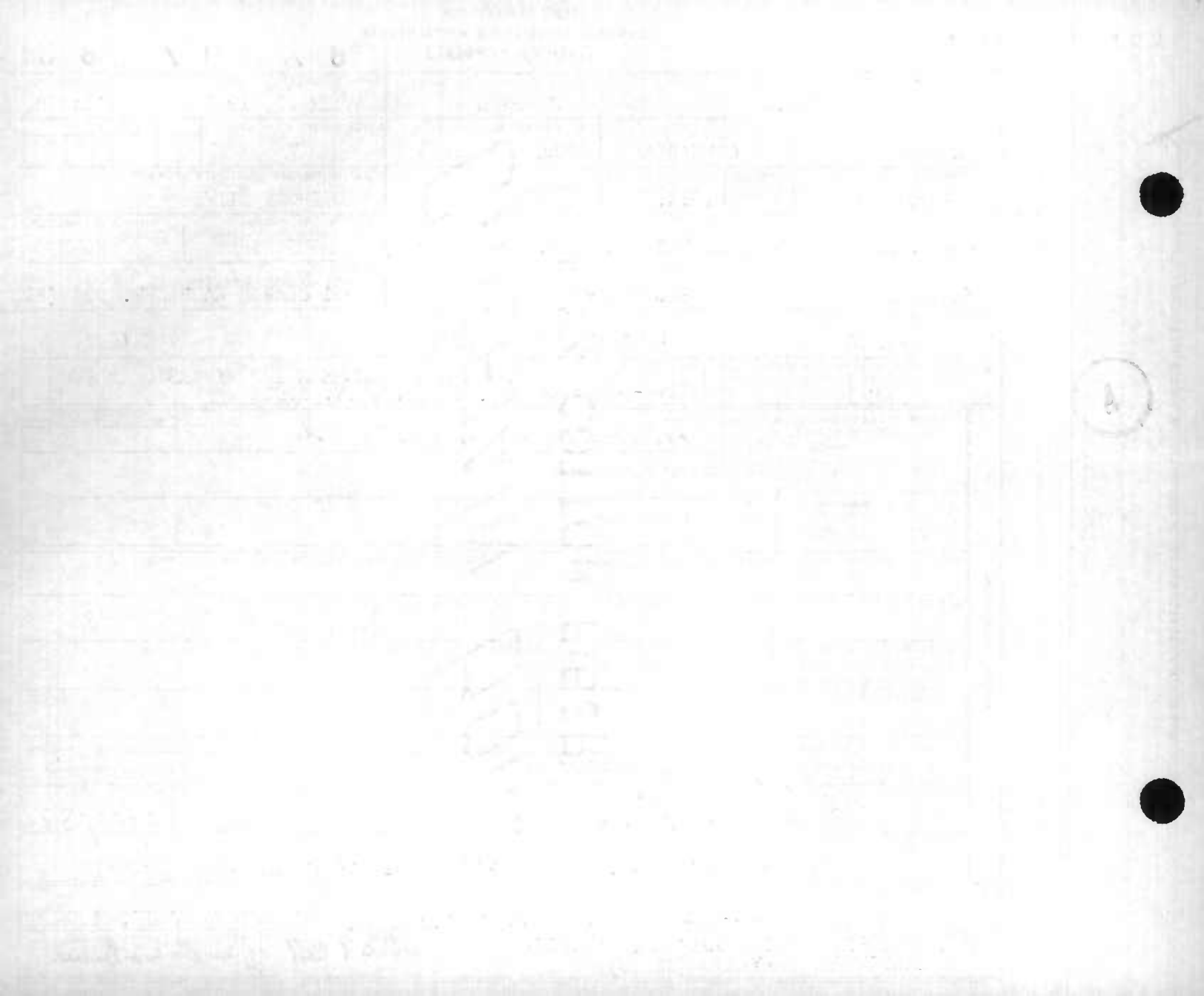
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07483

| | | | | | | | |
|--|--|--|--|---|---------------------------------|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
EVELYN JOHNSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 20, 1987 | | 2b. HOUR
11:10A _M | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 23, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3601 CLARKS LANE APT. 224 (21215) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3601 CLARKS LANE APT. 224 (21215) | | 14. FATHER'S NAME
FIRST MIDDLE LAST
MORRIS EPSTEIN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDITH WEISS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212--03-9334 | | 17. INFORMANT
JAMES ALLEN JOHNSON
ADDRESS
140 RIVERSIDE DRIVE
APT. 11D N.Y.N.Y. 10024 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC BREAST CA.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>3/10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Stephen N. Glasser M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/20/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN GLASSER MD. | | | | 22e. ADDRESS
1777 REISTERSTOWN ROAD #365 (21208) | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MAR. 22, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
OHEB SHALOM MEMORIAL BK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
REISTERSTOWN BALTO. MARYLAND | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS, 6010 REISTERSTOWN ROAD
BALTIMORE, MARYLAND (21215) | | | | 25. DATE RECEIVED BY REGISTRAR
MAR 27 1987 | | 25. REGISTRAR'S SIGNATURE
<u>Julia Gordon-Rudolph</u> | |

MEDICAL CERTIFICATION



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07484
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FAY MARGARET Johnson | | 2a. DATE OF DEATH
MONTH 7 DAY 20 YEAR 87 | | 2b. HOUR
17:45 | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH July DAY 14 YEAR 1903 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | 7. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 10. CITY OR TOWN OF DEATH
Frederick | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Frederick Memorial Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | 13. BALTIMORE CITY OR COUNTY OF DEATH
Frederick, MD. | |
| 13a. STATE
Pennsylvania | | 13b. COUNTY
Juniata | | 13c. CITY OR TOWN
Port Royal | |
| 14. FATHER'S NAME
FIRST Herbert MIDDLE Pensyl LAST Herbert | | 15. MOTHER'S MAIDEN NAME
FIRST Jennie MIDDLE Hertzog LAST Hertzog | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO.
196-14-7905B | | 17. INFORMANT
Mr. Mack Johnson | | ADDRESS
8201 Yellow Springs Road
Frederick, Md. 21701 | |

18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardio-Respiratory Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chronic solenion**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 9a. DATE OF OPERATION | | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 86 , to March , 19 87 , that (I) (we) viewed the deceased alive on 10-16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Grace E. Brooks | | | | DEGREE | | 22c. DATE SIGNED
3-20-1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Grace E. Brooks | | | | 22e. ADDRESS
487 7th St #4 Frederick, Md. 21701 | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Removal-Burial | | 23b. DATE
3-24-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
New Church Hill Cem. | | 23d. LOCATION
CITY OR TOWN Old Port, Juniata, Penna. COUNTY STATE | |
| 24. FUNERAL DIRECTOR
R. E. DAILEY & SON, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

A

44

047219 MAR 16 1987

FOR STATE REGISTRAR
3/16/87 DNDSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REF. NO. 07485

| | | | | | |
|---|--|--|---|--|---------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary B. Johnson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 9 87 | | 2b. HOUR
M |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 10 13 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 8. CITIZEN OF WHAT COUNTRY?
USA | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4120 Edmondson Ave. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. STREET ADDRESS / ZIP CODE
2121 Winter Garden Lane 21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Clayton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena Ball | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 17. SOCIAL SECURITY NO.
212-48-0602A | | 18. INFORMANT
Charles Clayton | | 19. ADDRESS
3126 Harford Rd. | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF, SP strokes</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21e. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21g. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21h. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Sher A Hashmi MD</u> | | DEGREE
MD | | 22c. DATE SIGNED
3-11-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SHER AFZAL HASHMI | | 22e. ADDRESS
9107 OLD HARFORD RD BALTIMORE 21234 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Cemetary | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Md. | | 23e. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
W.C. March F/H West 4300 Wabash Ave. | | 25. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

3300

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be notified at once.



049150 APR 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07486

| | | | | | |
|---|---|---|---|---|--------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Thalma W. Johnson | | | 2a. DATE OF DEATH MONTH DAY YEAR
Mar. 3 26 87 | | 2b. HOUR
M. |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH MONTH DAY YEAR
10 13 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH
City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House wife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 12a. STATE
MD. | 12b. COUNTY
1 | 12c. CITY OR TOWN
Balto | 12d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 12e. STREET ADDRESS / ZIP CODE
2503 Violet Ave. Apt. 903 21215 | |
| 13. FATHER'S NAME FIRST MIDDLE LAST
Charles Waprus | | 14. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lelia Stanku | | | |
| 15a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
N/A | | 15b. SOCIAL SECURITY NO.
219-01-2888 | | 15c. INFORMANT ADDRESS
Stanley Madison 3406 Ellamont Rd | |

| | | |
|--|--|---|
| 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):
Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b):
ASHD Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (c):
ASHD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
? |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Chronic Renal Failure - Diabetic Nephrosclerosis | | |

| | | | | | |
|---|--|---|--|---|--|
| 17a. DATE OF OPERATION | | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 85 to 19 PRESENT, that (I) (we) last saw the deceased alive on 27 Mar 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Curtis Davis | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CURTIS DAVIS MD | | 22e. ADDRESS
Bon Secours Hosp. | | | |

| | | | |
|--|---------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPONSOR)
Burial | 23b. DATE
4-1-87 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto MD. |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. Brown | | ADDRESS
1206 W. North Ave | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6147 MAR -8 07

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07487

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
TINA MARIA JOHNSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 3, 1987 | | 2b. HOUR P
3:09 M | | | | |
| 3. SEX
Female | | 4. RACE
Negroid | | 5. DATE OF BIRTH
MONTH DAY YEAR
3-29-66 | | 6. AGE (IN YEARS LAST BIRTHDAY)
20 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accounting | | 12b. KIND OF BUSINESS OR INDUSTRY
Business | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
(1a. STATE 11b. COUNTY 13c. CITY OR TOWN)
MD. BALTO. | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2031 E. 32nd St. 21218 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Rudolph C. Johnson Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Addie L. Cooke | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-96-6921 | | 17. INFORMANT ADDRESS
Rudolph Johnson 2031 E. 32nd St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) WITHDRAWAL OF MECHANICAL VENTILATION
DUE TO, OR AS A CONSEQUENCE OF (c) BRAIN DEATH | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
0 SECS
15 MINS
9 DAYS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
NOWA NONB HEPATITIS, CEREBRAL EDEMA, HEPATIC FAILURE, SEPSIS | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19, 19 87, to 3/3, 19 87, that (I) (we) lost
saw the deceased alive on 3/3, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Scott Carnvale MD | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/3/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SCOTT CARNVALE | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3-7-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Calvin B. Scruggs 1912 E. Preston St. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 04 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Denham-Rublee | | |

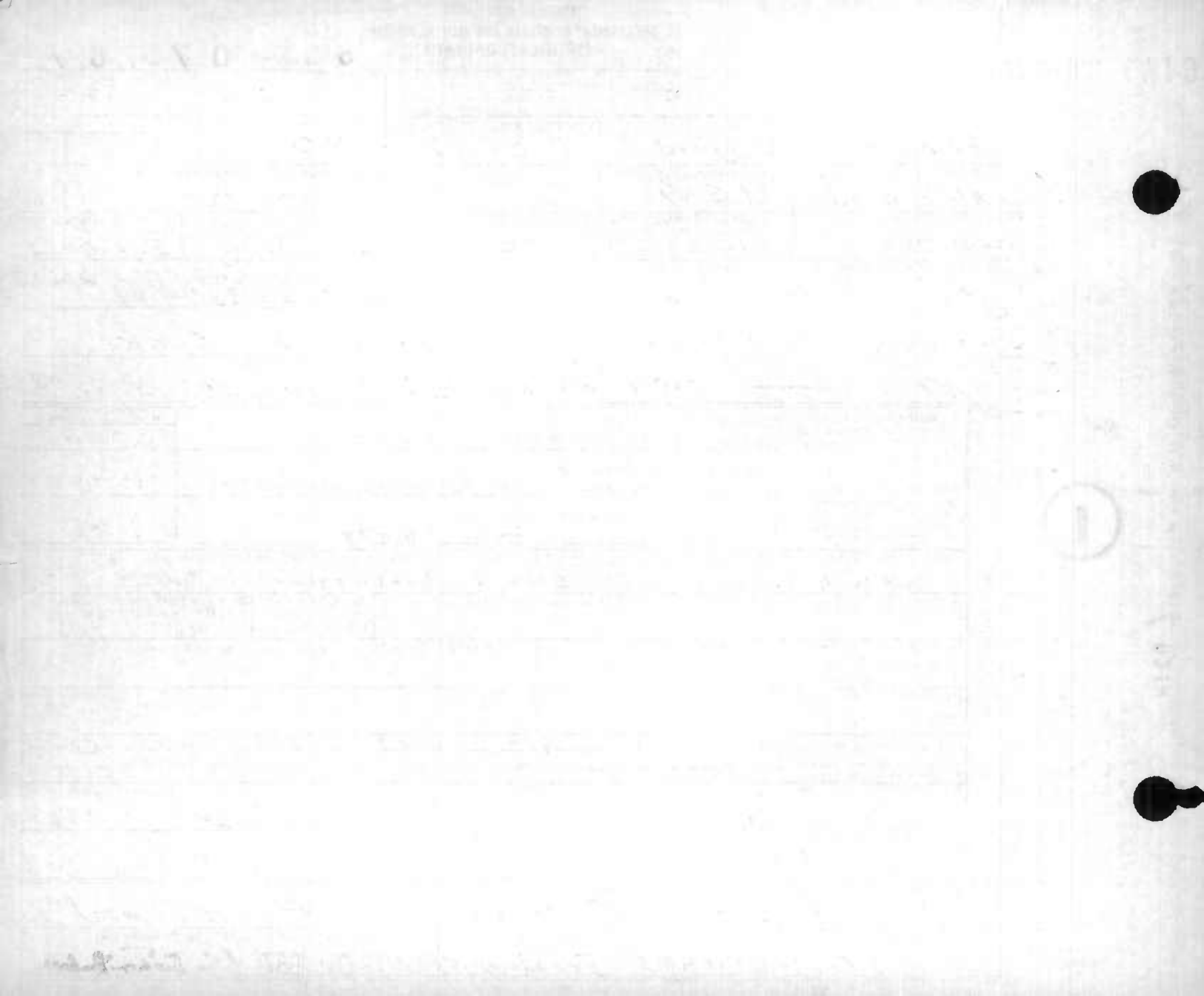
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please review corresponding pages. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



048650 MAR 3 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07488

| | | | | | |
|---|---|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Barbara Jonas | | | 2a DATE OF DEATH
MONTH DAY YEAR
3-27-87 | | 2b HOUR
500 M |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
Oct. 31, 1902 YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY)
84 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE
Md. | | | 13b COUNTY
Balto. | | 13c CITY OR TOWN
Towson |
| 14 FATHER'S NAME
Josef Tholen | | 15 MOTHER'S MAIDEN NAME
Agnes Hekden | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
214-38-9225 | | 17 INFORMANT ADDRESS
Mrs. Bertie Schmitz 1307 Felton Ct. 21093 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
224 hr |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>@ hip fracture 3 days prior to death</u> | | | | | |
| 19a DATE OF OPERATION
3-26-87 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>@ hip fracture</u> | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>3 P.M. 3-24 1987</u> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)
<u>fell backward while home alone</u> | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u>home</u> | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE
<u>Cross Campus Dr Baltimore Md</u> | |
| 22a I certify that (1) (this hospital) attended the deceased from <u>March 27 1987</u> to <u>March 27 1987</u> , that (1) (we) lost saw the deceased alive on <u>March 27 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. | | | | | |
| 22b SIGNATURE
<u>L. Olding MD</u> | | DEGREE
ATTENDING PHYSICIAN | | 22c DATE SIGNED
3-27-87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>L. OLDING</u> | | 22e ADDRESS
<u>Union Memorial Hosp</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
Mar. 30, 1987 | | 23c NAME OF CEMETERY OR CREMATORY
Parkwood | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 24 FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | 25a DATE REC'D. BY REGISTRAR
MAR 30 1987 | |
| 25b REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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Info. per phone - J.H.H. STATE OF MARYLAND
 1. FOR STATE REGISTRAR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO. 07489

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
 ANNETTE JONES

2a. DATE OF DEATH MONTH DAY YEAR
 FEBRUARY 24, 1987

2b. HOUR
 7:52^P M

3. SEX
 Female

4. RACE
 Black

5. DATE OF BIRTH MONTH DAY YEAR
 08 24 39

6. AGE (IN YEARS LAST BIRTHDAY) YRS
 47

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
 MD.

7b. CITIZEN OF WHAT COUNTRY?
 Yes

8. MARRIED ☐ NEVER MARRIED ☐
 WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
 BALTIMORE CITY MD

10. CITY OR TOWN OF DEATH
 BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
 THE JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE
 Md.

13b. COUNTY

13c. CITY OR TOWN
 Balto.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE
 5515 Summerfield AVE. 21206

14. FATHER'S NAME FIRST MIDDLE LAST
 Clarence Langley Elin Bates

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
 Elin Bates

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

17. INFORMANT ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) SEPTIC SHOCK
 DUE TO, OR AS A CONSEQUENCE OF
 (b) PROSTHETIC VALVE ENDOCARDITIS
 DUE TO, OR AS A CONSEQUENCE OF
 (c) RHEUMATIC HEART DISEASE
 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 72 HRS
 3 MOS.
 >40 YRS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
 RENAL FAILURE / LIVER FAILURE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
 P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 29, 1986, to FEBRUARY 24, 1987, that (I) (we) last saw the deceased live on FEBRUARY 24, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE
 Michael J. Grimm, MD

22c. DATE SIGNED
 2/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
 MICHAEL GRIMMETT

22e. ADDRESS
 600 N. WOLFE ST. BALT. MD 21205

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE
 2/28/87

23c. NAME OF CEMETERY OR CREMATORY
 ARBUTHNOTS MEM. PK.

23d. LOCATION CITY OR TOWN COUNTY STATE
 SULPHUR SPRING, RD. B. M. D.

24. FUNERAL DIRECTOR NAME ADDRESS
 Locks Funeral Home, 1304 N. B. Ave. Canton, MD

25a. DATE REC'D. BY REGISTRAR
 FEB 27 1987

25b. REGISTRAR'S SIGNATURE
 Julia Parker-Rodner

046240 MAR-1987

DIVISION OF VITAL RECORDS, 201-W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give to the funeral director the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ARTEMIA JONES | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 2, 1987 | | | 2b. HOUR
P M
3:28 P | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7/20/1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Puerto Rico | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH HOME, CITY OR TOWN)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3017 Mallview Rd., 21230 | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Isidoro Santos | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosalia Guzmán | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
061-16-6735 | | 17. INFORMANT ADDRESS
Paul R. Harris, Jr. Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) METABOLIC ABNORMALITIES
4 DAYS
(c) HEPATIC FAILURE
6 DAYS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MINUTES | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
RENAL FAILURE, PREVIOUS CARDIAC ARREST | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 27 19 87 to MARCH 2 19 87 , that I (we) lost saw the deceased alive on MARCH 2 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
David S. Raiford | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-2-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID S. RAIFORD, M.D. | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL
600 N. WOLFE ST. BALT, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Vet. Cem. of Crownsville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
McClully Funeral | | 24b. ADDRESS
237 E. Patapsco Ave.,
Homes Balto., Md. 21225 | | 25a. DATE REC'D. BY REG. MAR 24 1987 | | 25b. REGISTRAR SIGNATURE
Julia Davis | | | |

2

22

049392 APR - 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07491

| FOR
STATE
REGISTRAR | | FIRST | | MIDDLE | | LAST | | REG. NO. | |
|--|--|--|--|---|--|---|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | Calvin | | C. | | Jones | | III | |
| 2a. DATE KNOWN
OF DEATH | <input checked="" type="checkbox"/> ESTI-
MATED | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 3-28-87 | | 19 | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| Male | Black | 3/15/85 | | 2 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 2d. HOUR | |
| Md. | | USA | | | | Baltimore City | | 1:24A | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | |
| Baltimore | | University Hospital | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Md. | | H | | Westport Balt | | | | 2435 Westport St. 21230 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS | | | |
| Calvin C. Jones Jr. | | Rosalind James | | | | Rosalind James 2608 Hollin Ferry Rd. (30) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS | | 17. INFORMANT
ADDRESS | | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY:
8902 IMMEDIATE CAUSE (a) Smoke and soot inhalation and carbon monoxide
intoxication
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:09AM 3-28-87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
caught in a housefire | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
home 2nd fl. bedroom | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2435 Westport Street balto., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| ACTUAL
SIGNATURE
Margarita A. Korell, M.D. | | TITLE (SPECIFY)
Assistant | | DATE
3-28-87 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | 4/1/87 | | Mt. Auburn Cem | | Westport Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Chas. A. Rice FSPA 1300 Eutaw Place | | APR - 2 1987 | | Julia Seiden-Rendall | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL TRANSMITTAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (S))

4/9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

87 REG. NO. 07492

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LEROY H. JONES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 09 87 | | 2b. HOUR
7:50 p.m. |
| 3. SEX
Male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
7 19 1924 | 6. AGE (IN YEARS LAST BIRTHDAY)
62
YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
U S A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY
Westinghouse | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1604 E. Lafayette Avenue 21213 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
T-43 11/9/46 219-14-1529 | 17. INFORMANT
ADDRESS
Clara V. Jones 1604 E. Lafayette Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure (acute)
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetes Mellitus
DUE TO, OR AS A CONSEQUENCE OF
(c) Hepatic Encephalopathy | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
7 days
years
2-3 wks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Alcoholic liver disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 9, 19 87, to March 9, 19 87, that (I) (we) lost
saw the deceased alive on March 9, 19 87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
Stacy D. Ross | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STACY D. ROSS | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/14/87 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md | 23e. DATE REC'D. BY REGISTRAR
MAR 13 1987 | |
| 24. FUNERAL DIRECTOR
Wm. C. March F/H 1101 E. North Ave | | | 25. REGISTRAR'S SIGNATURE
Don Randle | | |

BP

201001010101



048349 MAR 27

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07493

| | | | | | | | |
|--|--|--|-------------------|------------------------------------|---|---|--------------|
| 1- FOR STATE REGISTRAR | | 20. DATE KNOWN OF DEATH ESTIMATED | | 21. DATE OF DEATH | | 22. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | |
| Lillie Rose Jones | | | | | | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 24 HRS. | 8. DATE PRONOUNCED DEAD | 9. MONTH | 10. DAY |
| F | B | 3 25 20 | 66 YRS. | | 3 19 87 | 3 | 19 |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 12. CITIZEN OF WHAT COUNTRY? | 13. MARRIED | 14. NEVER MARRIED | 15. DIVORCED | 16. BALTIMORE CITY OR COUNTY OF DEATH | | |
| VA | USA | | | | Baltimore City, MD | | |
| 17. CITY OR TOWN OF DEATH | 18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 20. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore City | Francis Scott Key Medical Center | RETIRED | | | | | |
| 21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 22. STATE | 23. COUNTY | 24. CITY OR TOWN | 25. INSIDE CITY LIMITS? | 26. STREET ADDRESS | 27. ZIP CODE |
| MD | | | BALTO. | | YES <input checked="" type="checkbox"/> | 6008 AMBERWOOD RD. | 21206 |
| 28. FATHER'S NAME | | 29. MOTHER'S MAIDEN NAME | | 30. ADDRESS | | 31. ZIP CODE | |
| ROBERT HENDRICKS | | LILLIE AUSTIN | | 21206 | | | |
| 32. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 33. SOCIAL SECURITY NO. | | 34. INFORMANT | | 35. ADDRESS | |
| NO | | 214208580 | | LONA M. WALKER | | 6008 AMBERWOOD RD. | |
| 36. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 37. IMMEDIATE CAUSE (a) | | 38. DUE TO, OR AS A CONSEQUENCE OF | | 39. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: | | Hypertensive & arteriosclerotic cardiovascular disease | | | | | |
| 40. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. | | (b) | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | Obesity | | | | | |
| 41. DATE OF OPERATION | | 42. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 43. AUTOPSY? | | 44. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 45. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 46. TIME OF INJURY | | 47. HOW INJURY OCCURRED | | 48. (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | | | |
| 49. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | 50. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 51. LOCATION | | 52. CITY OR TOWN | |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | COUNTY | |
| 53. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 54. TITLE (SPECIFY) | | 55. DATE SIGNED | |
| 56. ACTUAL SIGNATURE | | Assistant | | MEDICAL EXAMINER | | 3/19/87 | |
| 57. EXAMINER'S NAME (TYPE OR PRINT) | | William M. Zane, M.D. | | 58. ADDRESS | | 111 Penn St. Balto. MD. | |
| 59. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 60. DATE | | 61. NAME OF CEMETERY OR CREMATORY | | 62. LOCATION | |
| BURIAL | | 3/26/87 | | King Mem. Park | | RANDALLS TOWN | |
| 63. FUNERAL DIRECTOR | | 64. NAME | | 65. ADDRESS | | 66. DATE REC'D. BY REGISTRAR | |
| MARCH FUNERAL HOME | | 1101 E. NORTH AVE. | | | | MAR 24 1987 | |
| 67. REGISTRAR'S SIGNATURE | | 68. DATE | | 69. REGISTRAR'S SIGNATURE | | 70. DATE | |
| | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

8 REG. NO. 07494

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MACK JONES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 12, 1987 | | 2b. HOUR
1:00 am |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 20, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | 12b. KIND OF BUSINESS OR INDUSTRY
PRIVATE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
D.C. | 13b. COUNTY
WASHINGTON | 13c. CITY OR TOWN
WASHINGTON | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALBERT JONES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LILLIAN HIGGINS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | 17. INFORMANT ADDRESS
LILLIAN JONES 945 T. STREET N.W. WASHINGTON, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) XXXX CEREBROVASCULAR ACCIDENT with uncal herniation.
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 23, 1987 , to March 12, 1987 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 12, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 22b. SIGNATURE
Delefin Bernard | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DELEFIN BERNARD, MD | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
3-17-87 | 23c. NAME OF CEMETERY OR CREMATORY
HARMONY MEMORIAL PK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LANDOVER MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JOHNSON & JENKINS FH 716 KENNEDY STREET N.W. | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | 25b. REGISTRAR'S SIGNATURE
Delefin Bernard | |

4

1

RECEIVED

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARIE JONES | | | | | | | | | |
| 2a. DATE OF DEATH MONTH DAY YEAR HOUR
3-17-87 11:25a M | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
11 18 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
85 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE
MD | | | | 13c. COUNTY
BALTIMORE | | 13d. CITY OR TOWN
BALTIMORE | | 13e. STREET ADDRESS / ZIP CODE
1526 N APPLETON ST 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CHARLES | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARIA HULLETT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
213-36-5910 | | 17. INFORMANT ADDRESS
BESSIE K. DAVIS 1526 APPLETON ST. 21217 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST / RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-16 , 19 87 , to 3-16 , 19 87 , that (I) (we) last saw the deceased alive on 3-17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Stephen F. Settel MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN F. SETTEL | | | | 22e. ADDRESS
UNIV. OF MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ANNE ARUNDEL MD | | | |
| 24. FUNERAL DIRECTOR NAME
MARCH FUNERAL HOME | | | | ADDRESS
1101 E NORTH AVE. | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Fenderson | |

24



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate must be filed with the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows an injury, or other traumatic event, the medical examiner must be called at once.

046339 MAR 5

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07496

| | | | | | | | | |
|---|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
MARY | MIDDLE | LAST
JONES (STUBB) | 2a. DATE OF DEATH
MONTH DAY YEAR
3 2 87 | | 2b. HOUR
9:01 P.M. | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
12 25 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
GA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LIBERTY MED CENTER | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
721 Druid PK. DR. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA OLIVER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | |
| 16b. SOCIAL SECURITY NO.
259406374 | | 17. INFORMANT
ADDRESS
ESTELLE CAMPBELL 1605 LORMAN CT. 21217 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CARCINOMATOSIS PERITONEAL & DISTANT METASTASIS | | | | | | | | |
| 19a. DATE OF OPERATION
2/27/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
feeding gastrostomy | | | 20a. AUTOPSY?
NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2/87 to 3/2/87 that (I) (we) last saw the deceased alive on 3/2/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Dr. Qureshi | | | | DEGREE | | | 22c. DATE SIGNED
3-2-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Qureshi | | | | 22e. ADDRESS
Liberty Med. Center | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-10-87 | | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 06 1987 | | 25b. REGISTRAR'S SIGNATURE | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|---|---|--|
| 047493 MAR 1987 | | FOR STATE REGISTRAR | | 8 REG. NO. 07497 | |
| 1. DECEASED NAME
(TYPE OR PRINT) RAYMOND P. JONES SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-15-87 | | 2b. HOUR
MIN.
8:20 A.M. |
| 3. SEX
M | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
1-26-1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
415 S. TOLOMAC ST. | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
BETH-STEEL |
| 13a. STATE
MD. | | 13b. COUNTY | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LOUIS JONES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
KATHERINE UNKNOWN | | 13e. STREET ADDRESS / ZIP CODE
415 S. TOLOMAC ST. 21224 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
215-03-7676 | | 17. INFORMANT
ADDRESS
JOSEPHINE J. JONES SAME AS 15c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular arrest
DUE TO, OR AS A CONSEQUENCE OF ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Recurrent Aspiration Pneumonia CVA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1-1-87 , 19 87 , to 3-15-87 , 19 87 , that (we) lost
saw the deceased alive on 3-15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bayani B. Elma | | DEGREE
M.D. | | 22c. DATE SIGNED
3/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BAYANI B. ELMA | | 22e. ADDRESS
3623 Eastern Ave Balto 21224 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY
ST-STANISLAW CEM. | |
| 23d. LOCATION
CITY OR TOWN
BALTO. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
THOMAS J. SKARDIA | | ADDRESS
2829 HUDSON ST. | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | |
| 25b. REGISTRAR'S SIGNATURE
W. F. ... | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for registration, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07098

| | | | | | |
|--|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT W. JONES | | | 2a. DATE OF DEATH
MONTH 3 DAY 4 YEAR 87 | | 2b. HOUR
10:10 A.M. |
| 3. SEX
♂ | 4. RACE
B | 5. DATE OF BIRTH
MONTH 8 DAY 4 YEAR 45 | 6. AGE (IN YEARS LAST BIRTHDAY)
41 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY
McCormick |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2108 McCullough St. 21217 |
| 14. FATHER'S NAME
FIRST James MIDDLE W. LAST Jones | | 15. MOTHER'S MAIDEN NAME
FIRST Dorothy MIDDLE mc Kee LAST mc Kee | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
214-44-0018 | | 17. INFORMANT
Dorothy Walker ADDRESS
5318 Norwood AVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) SEPSIS | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
IV. DRUG ABUSE, HIV INFECTION. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2 , 19 87 , to 3/4 , 19 87 , that (I) (we) lost
saw the deceased alive on 3/4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
R. Dickstein MD | | DEGREE
MD | | 22c. DATE SIGNED
3/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DICKSTEIN MD | | 22e. ADDRESS
F.S.K. Hosp | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
3/9/87 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN Baltimore, Md. COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME Wm C March F/H West ADDRESS 4300 Wabash Ave. | | | 25a. DATE REC'D. BY REGISTRAR
MAR 06 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall |

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]



g. DATE REC'D. BY REGISTRAR 250 REGISTRAR'S SIGNATURE
MAR 31 1987 Julia Davidson-Rendell

1990



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and keep pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of page 710.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07500

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| FIRST MIDDLE LAST | | Male | | Black | |
| Horace Jordan | | | | | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| MONTH DAY YEAR | | 87 YRS | | M | |
| 12 3 1899 | | 87 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| N.C. | | U S A | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | | 4305 Ridgewood Ave. | | Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Retired | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md | | | | Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 4305 Ridgewood Avenue 21215 | |
| Thomas Jordan | | Lula Thompson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 216-10-6667 | | Ruth Simmons 4305 Ridgewood Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Chronic Obstructive Pulmonary Disease</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Osteoarthritis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>84</u> to <u>3-9</u> 19 <u>87</u> that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>3-9-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Perceval D. Smith</u> | | M.D. | | 4-1-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| | | 3100 Towanda Ave | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 4/3/87 | | Eastview Cemetery | |
| 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| CITY OR TOWN COUNTY STATE | | APR - 3 1987 | | <u>Julia D. Smith</u> | |
| Baltimore Md | | | | | |
| 24. FUNERAL DIRECTOR | | | | | |
| NAME ADDRESS | | | | | |
| Wm. C. March 4300 Wabash Avenue | | | | | |

BP

4/9

048329 MAR 27

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07501

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ludwig A. Jugo | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 23 1987 | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
November 29 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Hospital; | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | |
| 12b. KIND OF BUSINESS OR INDUSTRY
St. of Md. | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
3125 Elliott St.-21224 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ludwig Jugo | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Marecki | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
ADDRESS
Helen N. Jugo 3125 Elliott St. 21224 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerotic cardiovascular disease</u> <u>Years</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11/8</u> , 19 <u>73</u> , to <u>3/23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | 22b. SIGNATURE
<u>Louis E. Grenzer M.D.</u>
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>3/25/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Louis E. Grenzer</u> | | 22e. ADDRESS
<u>1101 N. Calvert St B. 140, 21202</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar. 27 '87 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Lilly & Zeiler, Inc. 1901 Eastern Ave. 21231 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed by a physician who attended the deceased within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove companion pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1

For the purpose of this investigation, the
data obtained from the various sources are

X

2/11/83 10:00 AM

For the purpose of this investigation, the
data obtained from the various sources are
2/11/83 10:00 AM

046625 MAR 11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONE, WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, OR CREMATION. PAGE 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Edwin L. Kaiss, Jr. | | | | | | | | | | | |
| 2. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
12/22/1925 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
61 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3-9-87 19 87 | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Auto-Capria & 5th Sts. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
chauffeur, Kane | | 12b. KIND OF BUSINESS OR INDUSTRY
TRANSFER | | 24. HOUR
5:38 A M | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY BALTIMORE | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS
21225 Hillcrest Ave. Balto. Md. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Edwin Kaiss | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna shade | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
219-10-4983 | | 17. INFORMANT
Mrs. Alice A. Kaiss, same as above | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive and Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles P. Kokes | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
3-9-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | ADDRESS
111 Penn St., Balto., MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial | | | | 23b. DATE
3/12/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon park cemt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
McGully Funeral Home, 130 E. Port Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |

FOR COLLECT GET

15/10/54



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07503

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|--|------------------|--|---|--|--|--|---|--|--|--|---|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| DIMITRIOS | | | | | | KAITIS, JR. | | 3-26-87 | | 19 | | | | | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 23 65 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
21 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 3-26-87 | | 10:01 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
painter | | | | 12b. KIND OF BUSINESS OR INDUSTRY
self Emp | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1101 Steelton Avenue 21224 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dimitrios Kaitis | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Emma Lentz | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Mary E. Kaitis 1101 Steelton Avenue 24 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8811 IMMEDIATE CAUSE (a) Thoracic trauma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
8:45AM 3-26-87 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject fell from scaffold | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
bridge | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1300 N. Bentalou St. Baltimore, Maryland | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED
3-26-87 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS
Margarita A. Korell, M.D., 111 Penn Street | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
3/30/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Cooksbury Metho. Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Abdington Md | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Walter G. Dabrowski | | | | ADDRESS
1005 Dundalk Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF A SIGNATURE. IN AN ATTEMPT TO PREVENT IT FROM BEING USED AS A BURIAL PERMIT, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, AND PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818,

Walter G. Dabrowski 1105 Dundalk Avenue

3/30/67

Serial

Cooksbury Metho. Cemetery Abingdon

MD

4

no

Utilities

Electric

Water

Gas

Mary E. Katis 1101 Steelton Avenue 1A

Baltimore

Maryland

Baltimore City

Painter

Self emp

USA

Baltimore, Md

male white 4 23 62 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Milton - Kaplan | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-23-87 | | 2b. HOUR
9:36 P.M. | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4-16-19 | | 6 AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chemist | | 12b. KIND OF BUSINESS OR INDUSTRY
Mineral Pigments Corp. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
12415 Buckley Drive 20914 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry - Kaplan | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ira - Hillman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO.
078-18-2301 | | 17. INFORMANT
ADDRESS
Ina E. Kaplan; Wife; 12415 Buckley Drive; Silver Spring, Md. 20904 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18h |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Portal Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis and Disseminated Intravascular Coagulation | | | | | | | | | 2-3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Acute Myelogenous Leukemia in Complete Remission / Transfusion Related HIV (+) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WHITE <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21 19 87 , to 3/23 19 87 , that (I) (we) last saw the deceased alive on 3/23/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (If (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | | DEGREE | | | 22c. DATE SIGNED
3/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kovitz | | | | | 22e. ADDRESS
University of Maryland Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Memorial Garden Olney; Montgomery; Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR'S NAME
DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | | | |
| 24. FUNERAL DIRECTOR'S ADDRESS
1170 Rockville Pike; Rockville, Md. 20852 | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

3-22-64 9:22 P.M.

Kaplan

Miller

WHITE

Male

4-10-64

101

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place on the certificate is marked with asterisks. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|---|--|---|---------------------------------------|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KARAGIANNOPOULOS, George | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 24 87 | | | 2b. HOUR
1220 ^P M | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
05 15 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GREECE | | 7b. CITIZEN OF WHAT COUNTRY?
Greece | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FSKMC | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Baker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Bakery | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
513 S. Tolna Street 21224 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Kostantinos Karagiannopoulos | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Vasiliki Benardou | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-62-8668 | | 17. INFORMANT ADDRESS
Mrs. Apostolia Karagiannopoulos
513 S. Tolna Street, Baltimore, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) sepsis 2 cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) pelvic abscess
DUE TO, OR AS A CONSEQUENCE OF
(c) urosepsis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Cardiac dysrhythmias, renal failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION
3/13/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
pelvic abscess | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/4 , 19 87 , to 3/24 , 19 87 , that (I) (we) last saw the deceased alive on 3/24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Augusto Bastidas | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/24/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BASTIDAS, J. Augusto | | | | 22e. ADDRESS
FSKMC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-26-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Ann Matthews, Matthews Funeral Home
3021 Eastern Ave., Baltimore, Md. 21224 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | | |

NOV

NOV

CO. 2 COL. 14th INF.

(A)

MAY 1 1891

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on page 4 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. The medical examiner's report is not required. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's report should be attached.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07506

| | | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Helen Karwacki | | | 2. DATE OF DEATH
MONTH DAY YEAR
3-8-87 | | | 2b. HOUR
2:40 A.M. | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 28, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center, Inc. | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 15. KIND OF BUSINESS OR INDUSTRY
Clothing Co. | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
Maryland | | | 16b. CITY OR TOWN
Baltimore | | 16c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16d. STREET ADDRESS / ZIP CODE
729 N. Kenwood Ave., 21205 | | | |
| 17. FATHER'S NAME
FIRST MIDDLE LAST
John Andrysiak | | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine unknown | | | | | | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 19b. SOCIAL SECURITY NO.
-- | | 19c. INFORMANT
Jerome Karwacki, same as above | | | | 19d. ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF,
(b) <u>CONGESTIVE HEART FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF,
(c) <u>ATHEROSCLEROTIC CARDIO VASCULAR DISEASE</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE, Atrial Fibrillation</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | 21g. CITY OR TOWN
COUNTY
STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-27-1987</u> to <u>3-8-1987</u> , that (I) (we) last saw the deceased alive on <u>3-8-1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Anil Raker</u> | | | DEGREE
MD. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-8-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANIL RAKER | | | 22e. ADDRESS
LIBERTY MEDICAL CENTER | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | | 23d. LOCATION
CITY OR TOWN
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
SCHIMUNEK FUNERAL HOME, Balto, Md. 21213 | | | 24b. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | 24c. REGISTRAR'S SIGNATURE
<u>Julia Borden-Randall</u> | | | | | |

BP

1. The first part of the report deals with the general conditions of the country during the year. It is a very interesting and valuable contribution to the knowledge of the country and its people. The author has done a very thorough and careful study of the country and its people, and his report is a very valuable contribution to the knowledge of the country and its people.

2. The second part of the report deals with the general conditions of the country during the year. It is a very interesting and valuable contribution to the knowledge of the country and its people. The author has done a very thorough and careful study of the country and its people, and his report is a very valuable contribution to the knowledge of the country and its people.

3. The third part of the report deals with the general conditions of the country during the year. It is a very interesting and valuable contribution to the knowledge of the country and its people. The author has done a very thorough and careful study of the country and its people, and his report is a very valuable contribution to the knowledge of the country and its people.

4. The fourth part of the report deals with the general conditions of the country during the year. It is a very interesting and valuable contribution to the knowledge of the country and its people. The author has done a very thorough and careful study of the country and its people, and his report is a very valuable contribution to the knowledge of the country and its people.

5. The fifth part of the report deals with the general conditions of the country during the year. It is a very interesting and valuable contribution to the knowledge of the country and its people. The author has done a very thorough and careful study of the country and its people, and his report is a very valuable contribution to the knowledge of the country and its people.

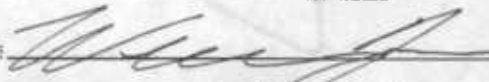



1011 E 1011

04787-1 MAR 23

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07507

| | | | | | | | | | | | | | | | | | |
|--|--|-----------------|------------------|---|--|---|--|---|------|---|--|---|-----------------------|--|---------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
CAROLYN | | | MIDDLE
KATZ | | | LAST | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR
M | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 4 55 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
31 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3 15 19 87 | | | 2d. HOUR
4:50 A.M. | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital (STU) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Accounting Dept | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Calvert Dist. | | | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Unit 22
8045 Greenleaf Terrace 21061 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley Waniewski | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Stella Gregorek | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-66-1973 | | | | 17. INFORMANT
Ricardo Katz | | | | ADDRESS
Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
8121 IMMEDIATE CAUSE (a) <u>Multiple injuries</u>
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1:10 PM 3-15- 19 87 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Passenger of auto/auto collision. | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Crain Hwy. & Bright View Rd., Anne Arundel, MD | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 3-15-87 | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
William M. Zane, M.D. | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
3/19/87 | | | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem | | | | 23d. LOCATION
Baltimore Baltimore STATE Md | | | | | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hgwy Balto Md | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | |

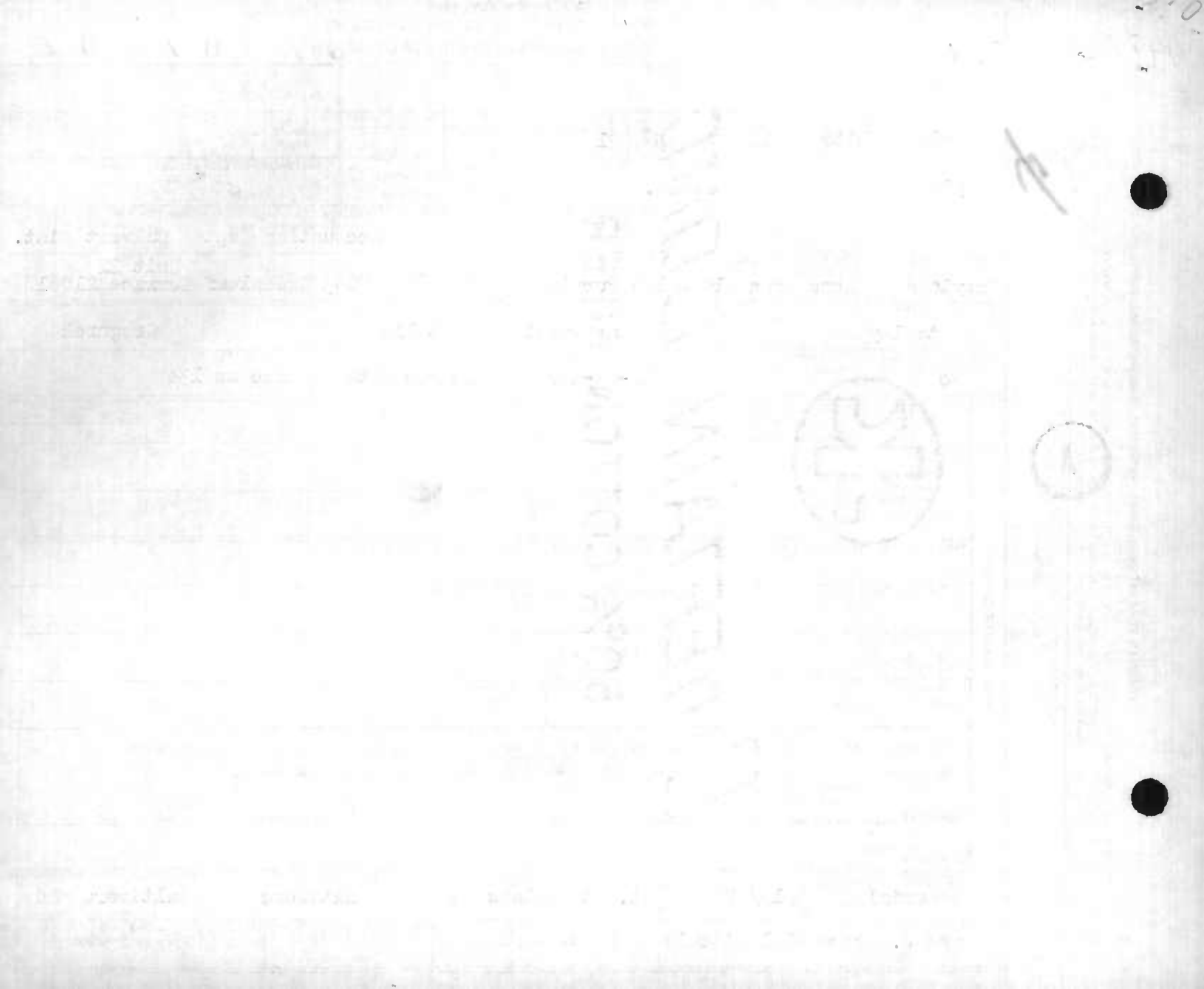
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07508

1- FOR
STATE
REGISTRAR

| | | | | |
|--|----------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OF PRINT) FIRST MIDDLE LAST
Earl Keaton | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
3 23 19 87 | | 2b. HOUR
M
A |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
9/28/31 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
55 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3-23-19 87 | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 2d. HOUR
M
A
2:22p |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital (DOA) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
MD | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
5136 Nelson Ave. 21215 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Keaton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mattie Madison | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
WWII
214-26-0210 | | 17. INFORMANT
ADDRESS
Gladys Keaton 5136 Nelson Ave. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | DATE SIGNED
3-24-87 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St. Balto., MD 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/28/87 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR
Heroy O. Dyett 4600 Liberty Heights | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
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DHMH - 17
(VR A15 ME (5))

8020

1000

1000

1000

1000



047403 MAR 12

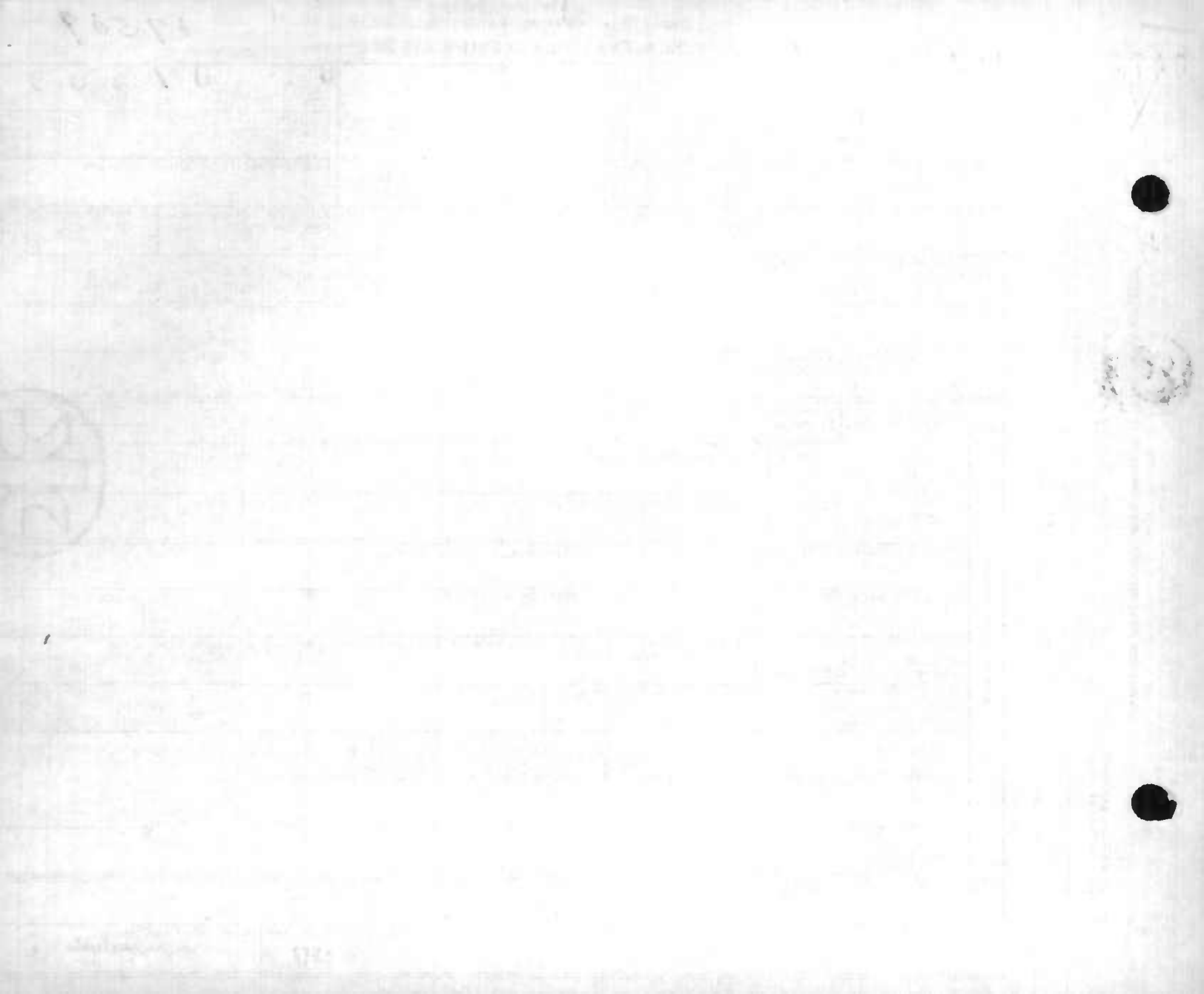
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07509

| | | | | | | | | | | | | | |
|--|--------|--|--|--|--|---|--|---|--|----------------------------|--|---|--|
| FOR
1- STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 3 DATE OF DEATH
KNOWN OF ESTI- MATED | | MONTH DAY YEAR | | 26 HOUR | |
| George | | | | | | Keaton, Sr | | 3 11 19 87 | | 3 11 19 87 | | 10:37 | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH
MONTH DAY YEAR | | 6 AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 7c DATE PRONOUNCED
DEAD | | 24 HOUR | |
| M | B | 8 10 24 | | 62 | | | | | | 3 11 19 87 | | 10:37 | |
| 7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Florida | | USA | | | | Baltimore City, | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | |
| Baltimore | | 3718 Yosemite | | Retired | | Francis Scott | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| Md. | | | | Balto. | | | | 3718 Yosemite Ave. | | | | 2125 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | |
| Albert | | Keaton | | Bessie | | Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 218-18-7592 | | Jerry Keaton | | 3718 Yosemite Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY)
M.D. Assistant | | MEDICAL EXAMINER | | DATE
SIGNED | | 3/12/87 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | William M. Zane, M.D. | | ADDRESS | | 111 Penn St. Balto, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 3/18/87 | | Md. Nat. Mem. Pk. | | Laurel, Md. | | | | | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Wm C March F/H West 4300 Wabash Ave. | | MAR 17 1987 | | [Signature] | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

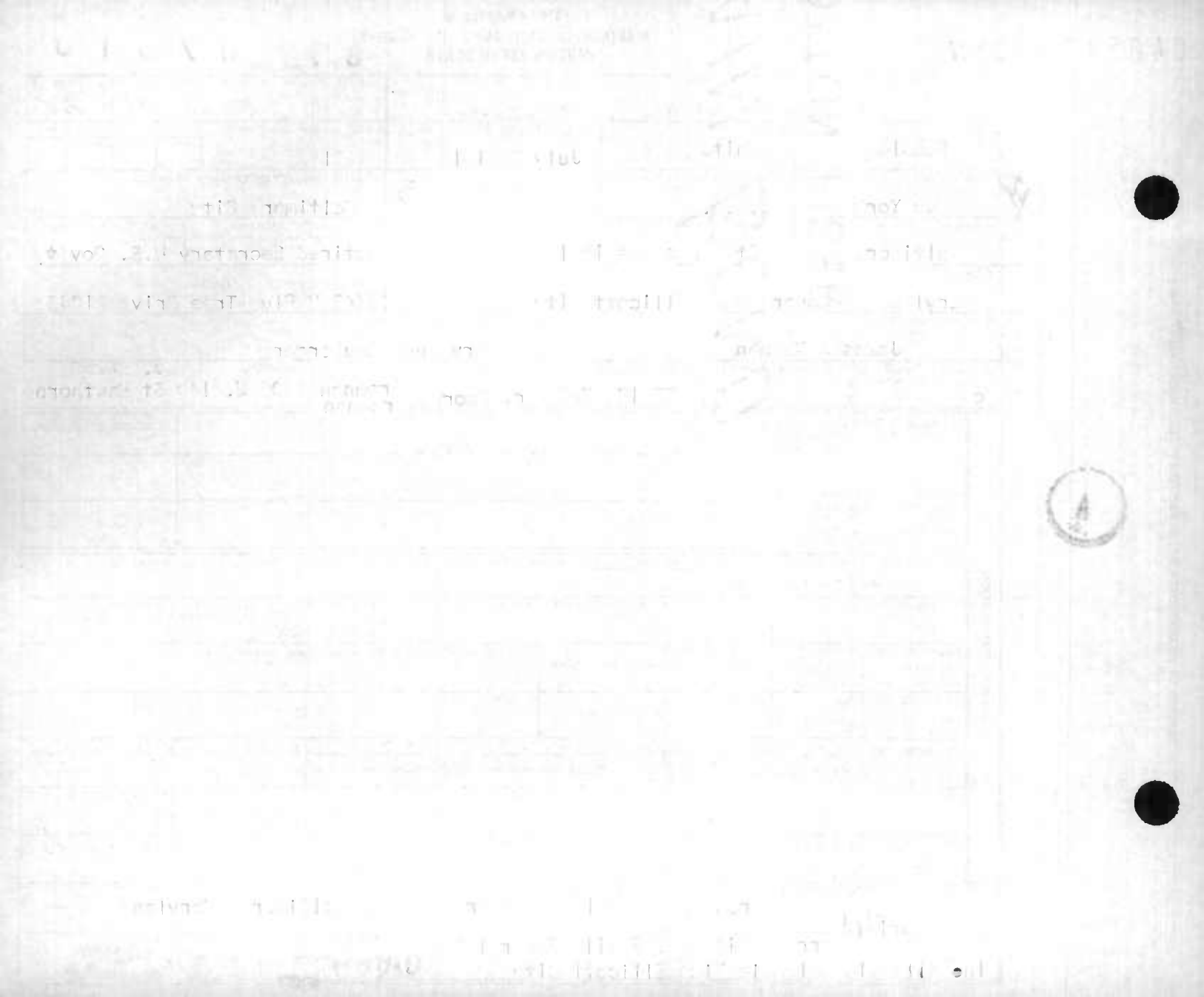
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then place in envelope of burial papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/transit. (Do not remove this certificate from the envelope.)

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Kathleen Marie Keenan</i> | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 22 87</i> | | | 2b. HOUR
<i>3 A M</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>July 7, 1915</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>71</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St Agnes Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired Secretary</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>U.S. Gov't</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
<i>Maryland Howard Ellicott City</i> | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>3447 H Plum Tree Drive 21043</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>James A Keenan</i> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Mary Ann Neuberger</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>577 12 8366</i> | | 17. INFORMANT
ADDRESS
<i>Mr. George Brennan 5405 W. 140 St Hawthorne Ca. 90250</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Malignant Lymphoma</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>pleural effusion</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/22</i> , 19 <i>87</i> , to <i>3/22</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>3/22/87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Monhee Lee</i> | | | | DEGREE | | | | 22c. DATE SIGNED
<i>3/22/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Monhee Lee</i> | | | | 22e. ADDRESS
<i>St. Agnes Hosp. 800 Canton Ave.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>March 25 '87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Holy Redeemer</i> | | 23d. LOCATION
<i>Baltimore Maryland</i> STATE | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Harry H Witzke & Family Funeral Home Inc 4112 Old Columbia Pike Ellicott City</i> | | | | | | | | | |
| 25. REGISTRAR'S SIGNATURE
<i>John K. ...</i> | | | | | | | | | |

MAR 27 1987



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07511

| | | | | | | | | | | | |
|--|--|---|--|---|--------|---|-------------------|--|-----|-----------------|---|
| 1. FOR
STATE
REGISTRAR | | DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| | | JOHN C. KEGEL | | | | | 03-05-87 | | | | 10:10A M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| MALE | | WHITE | | MONTH DAY YEAR
11-21-19 | | 67 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Baltimore | | US | | | | BALTIMORE CITY | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore City | | LEVINDALE Nsg HOME | | FOLDER OPERATOR | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | 21206 | |
| Md | | | | Baltimore | | | | 6517 BROOK AVENUE | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| John C. Kegel | | Augusta B. Gruebler | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| Army, Yes | | 220-09-1133 | | Elizabeth M. Kegel, | | 6517 Brook Ave. | | 21206 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC LUNG CA | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 2/19 19 87, to 3/5 19 87, that (we) lost saw the deceased alive on 3/5 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not see the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | |
| ESTRELITA O. KUL | | M.D. | | 3/5/87 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| ESTRELITA O. KUL | | LEVINDALE HEBRON GERMANIC CENTER HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 3-9-87 | | Parkwood Cemetery | | Balto. Balto., MD | | | | | |
| 24. FUNERAL DIRECTOR
John O. Miller, Inc., 6415 Belair Rd. 21206 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | MAR 06 1987 | | | | | |

RECEIVED 24 APR 64

REF 4210-00-054

14 01-17-04

14 01-17-04

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. When these pages are removed, the certificate should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene for registration, removal, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Alice E. Keller</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>3-15-87</i> | | 2b. HOUR
<i>8:05 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>1 13 07</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
<i>80</i> | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Balto., Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St. Agnes Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife/Housekeeper: Tmpl.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Masonic</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE
<i>Md.</i> | | | | 13b. COUNTY
<i>Balto.</i> | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>William Nicholson</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Margaret E. Weir</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
<i>220-12-9969D</i> | | 17. INFORMANT ADDRESS
<i>5424 Masfield Rd.-Balto., Md.</i> | | | |
| | | | | <i>Mrs. Edith M. O'Hara</i> | | <i>#21229</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis, cholangitis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>cancer of common bile duct</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/4</i> , 19 <i>87</i> , to <i>3/15</i> , 19 <i>87</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>3/15</i> , 19 <i>87</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Monhee Lee, M.D.</i> | | | | DEGREE
<i>MD</i> | | | | 22c. DATE SIGNED
<i>3/15/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Monhee Lee</i> | | | | 22e. ADDRESS
<i>St. Agnes Hosp 900 Calum St Baltimore MD 21229</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | | 23b. DATE
<i>3-18-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Lorraine Pk. Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Woodlawn, Balto. Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>G. Truman Schwab</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>4/10/87</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |
| 25c. ADDRESS
<i>5151 Balto. Nat'l. Pike #21229</i> | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO. 1513

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Naomi | | FIRST
A. | | MIDDLE
(Kelly) | | LAST
Keller | | 2b. DATE KNOWN
OF ESTI-
MATED
3/11/1987 | | 2c. DATE
PRONOUNCED
DEAD
3/11/1987 | | 2d. HOUR
5:30
a.m. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 16, 1918-68 | | 6. AGE (IN YEARS)
IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7. DATE
PRONOUNCED
DEAD
3/11/1987 | | 8. TIME
5:30
a.m. | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS
OR INDUSTRY
--- | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
910 Fawn Street, 21202 | | | | | |
| 14. FATHER'S NAME
FIRST
? | | MIDDLE
? | | LAST
Baker | | 15. MOTHER'S MAIDEN NAME
FIRST
Gertrude | | MIDDLE
--- | | LAST
Betz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-12-4683A | | 17. INFORMANT
Mr. Robert D. Siford - Son | | ADDRESS
4059 St. Augustine Lane - Balto., Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
9018 IMMEDIATE CAUSE (a) Hypothermia
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
21222. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Alcoholism | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 3/11/1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject found at home without heat | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET
910 Fawn St., Balto. City, Md. | | CITY OR TOWN
BALTIMORE | | COUNTY
BALTIMORE | | STATE
MARYLAND | | | |
| 22a. I certify that I took charge of the remains described above, held in
death resulted from: Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
Gregory R. Kauffman, M.D. | | TITLE (SPECIFY)
M.D. Assistant | | MEDICAL EXAMINER | | DATE
SIGNED
3/11/87 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS
111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN
Baltimore, Maryland | | COUNTY
BALTIMORE | | STATE
MARYLAND | | | |
| 24. FUNERAL DIRECTOR
John A. Moran, Inc. Funeral Home | | ADDRESS
3000 E. Baltimore St., Baltimore, Md. | | DATE REC'D. BY REGISTRAR
MAR 16 1987 | | REGISTRAR'S SIGNATURE
John A. Moran | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, return page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a case.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 REG. NO. | 07514 |
|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Florence K. Kelly | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 13 87
M | |
| 3 SEX
Female | 4 RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
5 17 06 | | 6 AGE (IN YEARS LAST BIRTHDAY)
80 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3227 Westmont Ave. 21216 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unkn | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Belinda King | | 13e. STREET ADDRESS / ZIP CODE
301 McMecken St. Apt/ 612 21217 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-36-1488 | | 17. INFORMANT
ADDRESS
Sarah L. White Buffalou, N.Y.
347 Woodlawn Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15/87, 1987, to 2/21, 1987 that (I) (we) lost saw the deceased alive on 3/12/87 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
RAMESH SA BAPATHY | | DEGREE | | 22c. DATE SIGNED
3/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAMESH SA BAPATHY | | 22e. ADDRESS
MARYLAND GENERAL HOSPITAL, 800 827 HINDEN AVE BALTIMORE MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/17/87 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Nat. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H West | | ADDRESS
4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | |

STATIONER

1914

COPIES



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07515
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|---|---|---|---|--|--|---------------------|--------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
LESSIE KELLY. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/29/87 | | | 2b. HOUR
3:55 PM | |
| 3. SEX
Female | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
12/21/08 | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(COUNTRY)
Millsville, Va. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Balt. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Ches. Gen. Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Md | 13b. COUNTY | 13c. CITY OR TOWN
Balt. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1214 Eutaw St. 21217 | | |

| | | | |
|--|--|---|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Hunter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Scott | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
N/A | |
| 17. INFORMANT
Theima Carter | | ADDRESS
3601 E. Virginia Beach | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest due to
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Myocardial Infarction | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

| | | | | | | | |
|--|--|---|--|----------------|--|-----------------------------|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 11:23 PM 1987 to 3:29 AM 1987, that (I) (we) lost
saw the deceased alive on 3/29/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
R. M. Shah M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
3/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. M. SHAH, M.D. | | 22e. ADDRESS
North Charles Gen Hospital
Baltimore, MD. 21218. | | | | | |

| | | | | | | | |
|--|--|---------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balt. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett & Son | | | | ADDRESS
4600 Liberty Heights | | 25a. DATE REC'D. BY REGISTRAR
APR - 2 1987 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, this should be immediately filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

4/9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMMH - 16 60M 7/84
(VIA 15. 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07516
REG. NO.

| | | | | | |
|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Mary C. Kelly | | MONTH DAY YEAR
3 28 87 | | 5:40 A.M. | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
5 23 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD U.S.A. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. of A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp | | 12a. USUAL OCCUPATION (TYPE OR FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Housewife |
| 13a. STATE
MD. | | 13b. COUNTY
AA Co. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dyson Edward Dyson | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Pearline Edwards | | 16. SOCIAL SECURITY NO.
217-74 2910 | |
| 17. INFORMANT
ADDRESS
21122 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic Renal failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Sepsis</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/19</u> , 19 <u>87</u> , to <u>3/28</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Cheng Wai-fung | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHENG, WAI - FUNG | | 22e. ADDRESS
South Baltimore General Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
4/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
MAGOTHY (AA Co.) MD. | | 23e. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
LEWIS T. GWYNN | | ADDRESS
4517 PARK HEIGHTS AVENUE | | 25a. REGISTRAR'S SIGNATURE
Davidson-Rendell | |

BP

4

DIVISION OF VITAL RECORDS, 281 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

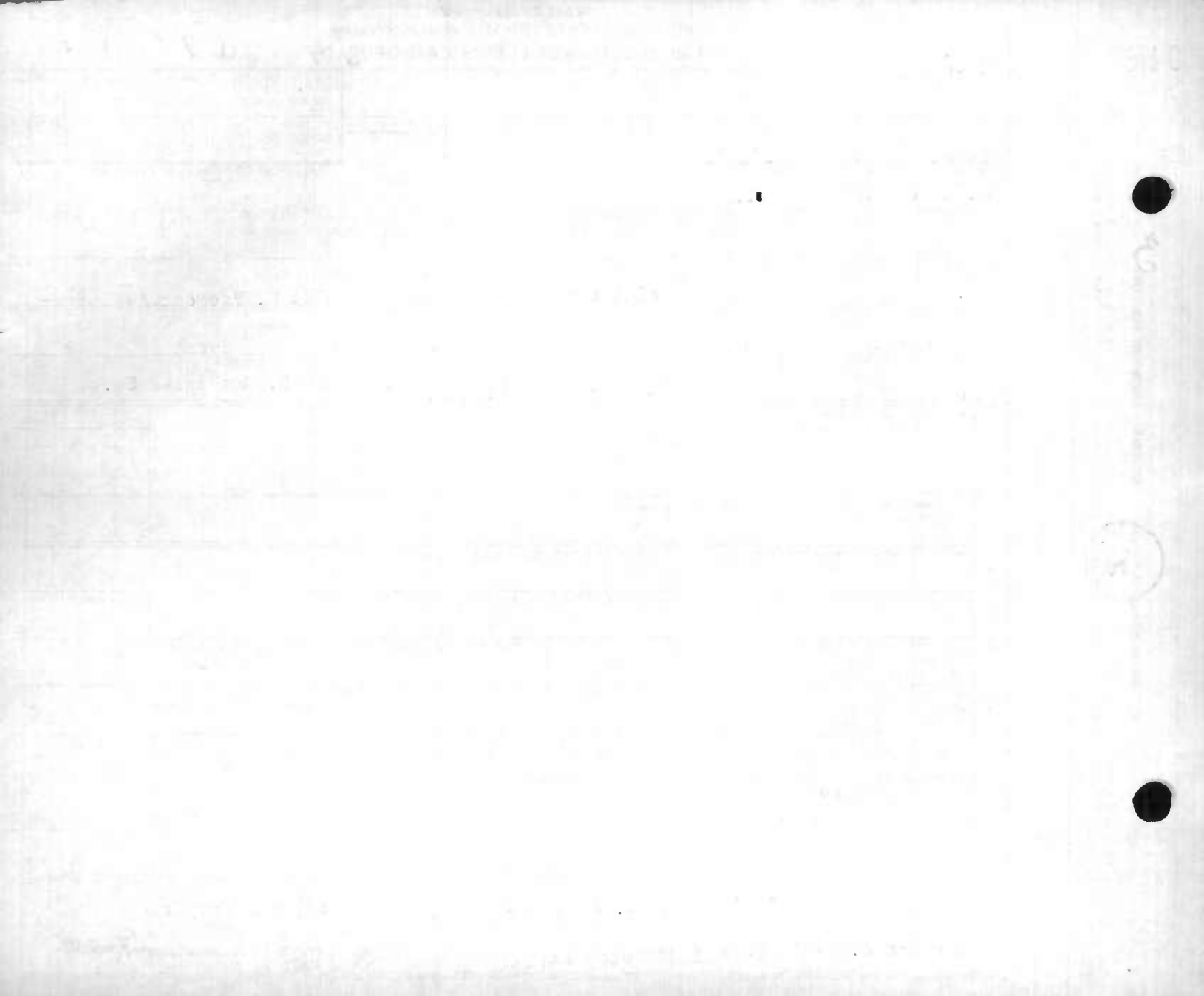
DHMH - 17

(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 07517

| | | | | | | | |
|--|--|--|---|---|--------------------------------------|--------------------------------------|---|
| FOR
1- STATE
REGISTRAR | | 3- FOR DEATH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REC'D. NO. 07517 | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | |
| JOSEPHINE | | | | KEMP | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS)
(LAST BIRTHDAY) | 7. IF UNDER 1 YR.
MONTHS DAYS | 8. IF UNDER 24 HRS.
HOURS MIN | 2c. DATE
PRONOUNCED
DEAD | 2b. DATE KNOWN
OF ESTI-
DEATH MATED |
| Female | Black | 1/16/1912 | 75 YRS. | | | 3-26-87 | 3-25-87 |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| N. Carolina | USA | | | | Baltimore City | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | |
| Baltimore | 221 N. Fremont Ave. | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| 13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. 221 N. Fremont Ave 21201 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| Robert Evert | | | | Carrie Kemp Evert | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 218-32-4584 | | Sherman Kemp 129 S. Catherine St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY) | | | | DATE
SIGNED | |
| Margarita A. Korell, M.D. | | Assistant MEDICAL EXAMINER | | | | 3-26-87 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | |
| Margarita A. Korell, M.D. | | 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
OF BODY | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | 3/30/87 | Mt. Auburn Cemetery | | Westport, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Charles A. Rice FSPA 1300 Eutaw Pl, | | | | MAR 30 1987 | | John Davidson-Hendall | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Harry Daniel Kernan, Sr. | | | | | | | | March 18, 1987 | | 9:12PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| Male | | White | | March 1 1923 | | 64 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Union Memorial Hospital | | | | | | Equip. Opr. | | City Hwys. Balto. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | 21213 | |
| Md. | | | | Baltimore | | | | 3648 Chesterfield Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| John Kernan | | | | Flora Garcia | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT, UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| no | | | | 215-12-9302 | | Antoinette Kernan (wife) same address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line in 18a, 18b, and 18c.) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Lung cancer with multiple metastases | | | | | | | | | | months | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| Atherosclerotic cardiovascular disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from June 1985, to Nov 1987, that (1) (we) last saw the deceased alive on March 5, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | | |
| 22b. SIGNATURE Chi-Sheng Chen | | | | | | | | | | 22c. DATE SIGNED 3-20-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Chen | | | | | | | | | | 22e. ADDRESS Church Hospital Corp. | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 3/21/87 | | Lakeview Mem. Pk. | | Baltimore | | Md. | | | |
| 24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| 3331 Brehms Lane, Balto. Md. 21213 | | | | | | MAR 24 1987 | | James Gordon-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Margaret Kerrigan | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 19 1987 | | | 2b. HOUR
10:30AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 28 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5220 York Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookbinder | | 12b. KIND OF BUSINESS OR INDUSTRY
Waverly Press | |
| 13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5220 York Rd. Apt. 6 S | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Quinn | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kate Mahon | | | | 21212 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-14-0823A | | 17. INFORMANT
ADDRESS
Kathleen Ryder (sister) 5220 York Rd. Apt 5H | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Artery Dis
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4 yrs | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
Leukemoid Reaction | | | | | | | | | |
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
NA 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
NA | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Feb. 2 , 19 82 , to March 19 , 19 87 , that (I) (we) last saw the deceased alive on 2-10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Dr. Bannister Raines
22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3-20-87 | |
| 22d. ADDRESS
5225 York Rd., Govans Multi Med Cen | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL HOME
NAME
Bethmuneck Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | | 25b. REGISTRAR'S SIGNATURE
John B. ... | | | |

BP

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Please note: This certificate must be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07520
REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE FLYNN LAST KETLER
Mary F. Ketler | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 13, 1987 | | 2b. HOUR
7:47 PM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-3-01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS
IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Unknown | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael Flynn | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Freeman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-01-7948 | | 17. INFORMANT
ADDRESS
M.C. Ketler 523 Murdock Road 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Coronary artery disease, hypertension, congestive heart failure, and pneumonia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
March 2, 1987 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Status post ileostomy/colostomy | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>February 24,</u> 19 <u>87</u> , to <u>March 13,</u> 19 <u>87</u> , that (X) (we) lost saw the deceased alive on <u>March 13,</u> 19 <u>87</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>David L. Gold MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/14/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David L. Gold M.D. | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home | | | | ADDRESS
6500 York Road 21212 | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>David L. Gold</u> | |

| No. | | Name | | Origin | | Remarks | |
|-----|--|--------|--|----------------|--|---------|--|
| 1 | | Cotton | | Alabama | | Ginn | |
| 2 | | Cotton | | Mississippi | | Ginn | |
| 3 | | Cotton | | Louisiana | | Ginn | |
| 4 | | Cotton | | Texas | | Ginn | |
| 5 | | Cotton | | California | | Ginn | |
| 6 | | Cotton | | Arizona | | Ginn | |
| 7 | | Cotton | | New Mexico | | Ginn | |
| 8 | | Cotton | | Colorado | | Ginn | |
| 9 | | Cotton | | Utah | | Ginn | |
| 10 | | Cotton | | Idaho | | Ginn | |
| 11 | | Cotton | | Montana | | Ginn | |
| 12 | | Cotton | | Wyoming | | Ginn | |
| 13 | | Cotton | | Nebraska | | Ginn | |
| 14 | | Cotton | | Kansas | | Ginn | |
| 15 | | Cotton | | Oklahoma | | Ginn | |
| 16 | | Cotton | | Arkansas | | Ginn | |
| 17 | | Cotton | | Missouri | | Ginn | |
| 18 | | Cotton | | Illinois | | Ginn | |
| 19 | | Cotton | | Indiana | | Ginn | |
| 20 | | Cotton | | Ohio | | Ginn | |
| 21 | | Cotton | | Pennsylvania | | Ginn | |
| 22 | | Cotton | | Maryland | | Ginn | |
| 23 | | Cotton | | Delaware | | Ginn | |
| 24 | | Cotton | | Virginia | | Ginn | |
| 25 | | Cotton | | North Carolina | | Ginn | |
| 26 | | Cotton | | South Carolina | | Ginn | |
| 27 | | Cotton | | Georgia | | Ginn | |
| 28 | | Cotton | | Florida | | Ginn | |
| 29 | | Cotton | | Alabama | | Ginn | |
| 30 | | Cotton | | Mississippi | | Ginn | |
| 31 | | Cotton | | Louisiana | | Ginn | |
| 32 | | Cotton | | Texas | | Ginn | |
| 33 | | Cotton | | California | | Ginn | |
| 34 | | Cotton | | Arizona | | Ginn | |
| 35 | | Cotton | | New Mexico | | Ginn | |
| 36 | | Cotton | | Colorado | | Ginn | |
| 37 | | Cotton | | Utah | | Ginn | |
| 38 | | Cotton | | Idaho | | Ginn | |
| 39 | | Cotton | | Montana | | Ginn | |
| 40 | | Cotton | | Wyoming | | Ginn | |
| 41 | | Cotton | | Nebraska | | Ginn | |
| 42 | | Cotton | | Kansas | | Ginn | |
| 43 | | Cotton | | Oklahoma | | Ginn | |
| 44 | | Cotton | | Arkansas | | Ginn | |
| 45 | | Cotton | | Missouri | | Ginn | |
| 46 | | Cotton | | Illinois | | Ginn | |
| 47 | | Cotton | | Indiana | | Ginn | |
| 48 | | Cotton | | Ohio | | Ginn | |
| 49 | | Cotton | | Pennsylvania | | Ginn | |
| 50 | | Cotton | | Maryland | | Ginn | |
| 51 | | Cotton | | Delaware | | Ginn | |
| 52 | | Cotton | | Virginia | | Ginn | |
| 53 | | Cotton | | North Carolina | | Ginn | |
| 54 | | Cotton | | South Carolina | | Ginn | |
| 55 | | Cotton | | Georgia | | Ginn | |
| 56 | | Cotton | | Florida | | Ginn | |
| 57 | | Cotton | | Alabama | | Ginn | |
| 58 | | Cotton | | Mississippi | | Ginn | |
| 59 | | Cotton | | Louisiana | | Ginn | |
| 60 | | Cotton | | Texas | | Ginn | |
| 61 | | Cotton | | California | | Ginn | |
| 62 | | Cotton | | Arizona | | Ginn | |
| 63 | | Cotton | | New Mexico | | Ginn | |
| 64 | | Cotton | | Colorado | | Ginn | |
| 65 | | Cotton | | Utah | | Ginn | |
| 66 | | Cotton | | Idaho | | Ginn | |
| 67 | | Cotton | | Montana | | Ginn | |
| 68 | | Cotton | | Wyoming | | Ginn | |
| 69 | | Cotton | | Nebraska | | Ginn | |
| 70 | | Cotton | | Kansas | | Ginn | |
| 71 | | Cotton | | Oklahoma | | Ginn | |
| 72 | | Cotton | | Arkansas | | Ginn | |
| 73 | | Cotton | | Missouri | | Ginn | |
| 74 | | Cotton | | Illinois | | Ginn | |
| 75 | | Cotton | | Indiana | | Ginn | |
| 76 | | Cotton | | Ohio | | Ginn | |
| 77 | | Cotton | | Pennsylvania | | Ginn | |
| 78 | | Cotton | | Maryland | | Ginn | |
| 79 | | Cotton | | Delaware | | Ginn | |
| 80 | | Cotton | | Virginia | | Ginn | |
| 81 | | Cotton | | North Carolina | | Ginn | |
| 82 | | Cotton | | South Carolina | | Ginn | |
| 83 | | Cotton | | Georgia | | Ginn | |
| 84 | | Cotton | | Florida | | Ginn | |
| 85 | | Cotton | | Alabama | | Ginn | |
| 86 | | Cotton | | Mississippi | | Ginn | |
| 87 | | Cotton | | Louisiana | | Ginn | |
| 88 | | Cotton | | Texas | | Ginn | |
| 89 | | Cotton | | California | | Ginn | |
| 90 | | Cotton | | Arizona | | Ginn | |
| 91 | | Cotton | | New Mexico | | Ginn | |
| 92 | | Cotton | | Colorado | | Ginn | |
| 93 | | Cotton | | Utah | | Ginn | |
| 94 | | Cotton | | Idaho | | Ginn | |
| 95 | | Cotton | | Montana | | Ginn | |
| 96 | | Cotton | | Wyoming | | Ginn | |
| 97 | | Cotton | | Nebraska | | Ginn | |
| 98 | | Cotton | | Kansas | | Ginn | |
| 99 | | Cotton | | Oklahoma | | Ginn | |
| 100 | | Cotton | | Arkansas | | Ginn | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07521
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|-------------------------------------|----------------------------------|
| 1 DECEASED NAME
(TYPE OR PRINT) | | 2a DATE OF DEATH | | 2b HOUR | |
| FIRST MIDDLE LAST
<i>John Gordon Keys</i> | | MONTH DAY YEAR
<i>3-29-87</i> | | 5AM | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| <i>male</i> | <i>white</i> | MONTH DAY YEAR
<i>10-2-1915</i> | | <i>71</i> YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| <i>Maryland</i> | <i>USA</i> | | | <i>Baltimore city MD.</i> | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| <i>Baltimore</i> | <i>Lafayette Square Nursing Center</i> | | <i>center</i> | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. STREET ADDRESS / ZIP CODE | |
| <i>Maryland</i> | | <i>BALTO.</i> | <i>BALTO.</i> | <i>1731 Harford Ave. MD 21213</i> | |
| 14. FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
<i>WILLIAM F. KEYS</i> | | FIRST MIDDLE LAST
<i>EDNA M. ROHRBAUGH</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| <i>NO</i> | | <i>215050838A</i> | | <i>FAMILY RECORDS</i> | |

| | | | |
|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Brb Arrhythmias</i> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCD</i> | | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *CHF - Left Heart Failure - Ex of E. Keener*

| | | | |
|--|--|--|--|
| 19a DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-2-1965</i> to <i>3-29-1987</i> , that (I) (we) lost
saw the deceased alive on <i>3-29-1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Mohammad Aslam</i> | | 22c. DATE SIGNED | |
| DEGREE
<i>M.D.</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MOHAMMAD ASLAM M.D.</i> | | 22e. ADDRESS
<i>300-ARMORY PLACE BALTO. MD.</i> | |

| | | | |
|--|-------------------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| <i>BURIAL</i> | <i>04-01-1987</i> | <i>PARKWOOD CEM</i> | <i>PARKVILLE BALTO CO. MD.</i> |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
<i>EVANS CHAPEL OF MEMORIES</i> | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| | | <i>APR - 3 1987</i> | <i>Juan Davidson-Randall</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate, page 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07522

FOR
1- STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Charles

Kiefer Jr.

2a. DATE OF DEATH

MONTH

DAY

YEAR

March 3 1987

2b. HOUR

M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

May 22 1924

6. AGE (IN YEARS LAST BIRTHDAY)

62

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

4819 Hazelwood Ave.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Restaurant Owner

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Balto.

13c. CITY OR TOWN

Balto.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4819 Hazelwood Ave. 21206

14. FATHER'S NAME

Charles

MIDDLE

Kiefer Sr.

15. MOTHER'S MAIDEN NAME

Nora

MIDDLE

Biemiller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

yes

WWII

16b. SOCIAL SECURITY NO.

218-12-2101

17. INFORMANT

ADDRESS

Virginia Kiefer 4819 Hazelwood Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

METASTATIC LUNG CANCER.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last:

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING ☒ MEDICAL ☒ STAFF
PHYSICIAN DIRECTOR PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

G. U. STUART JR MD

22e. ADDRESS

404 EASTERN BLVD BALTO 21221

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

3/6/87

23c. NAME OF CEMETERY OR CREMATORY

Holly Hill Cemetery Middle River Balto. Md.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME ADDRESS
Connelly Funeral Home 300 Mace Ave. 21221

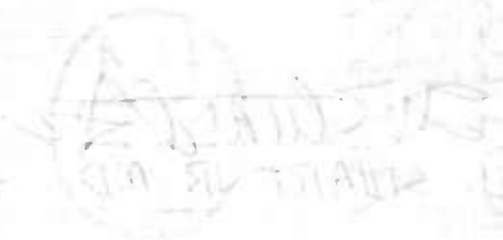
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MAR 10 1987

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

METASTATIC LUNG CANCER



STATE OF NEW YORK
COUNTY OF ALBANY

046563 MAR 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 075223

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELEANOR C. KILBY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 7 87 | | 2b. HOUR
7:30 AM |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
2 29 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore, | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Kapuscinski | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Tomatzki | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
219-22-8155 | | 17. INFORMANT
ADDRESS
Elza Kilby 317 S. Castle Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
S/P FEMORAL POPLITEAL BY-PASS | | | | | |
| 19a. DATE OF OPERATION
3/5/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/4 1987 to 3/7 1987, that (I) (we) lost saw the deceased alive on 3/6 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
T. Emanuele, MD | | DEGREE | | 22c. DATE SIGNED
3/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TULLIO EMANUELE | | 22e. ADDRESS
5601 LOCH RAVEN BLVD
BALTO MD 21234 | | 22f. ADDRESS
ELKRIDGE MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-10-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ELKRIDGE MD. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
JOHN M. WEBER & SONS INC. 401 S. CHESTER ST. | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

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048230 MAR 25 1987

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO.

07524
3-17-87 6:55 PM

| | | | |
|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MALE KIM | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-17-87 6:55 PM | |
| 3. SEX
Male | 4. RACE
KOREAN | 5. DATE OF BIRTH
MONTH DAY YEAR
3-17-87 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
3-17-87 1 06 | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp. | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
None | |
| 13a. STREET
1301 Bayard St. | 13b. CITY OR TOWN
Balto. | 13c. STREET ADDRESS / ZIP CODE
1301 Bayard St., Balto., Md. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JONG KIM | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IN UNK | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
— | 17. INFORMANT
Admission sheet | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anencephalic
DUE TO, OR AS A CONSEQUENCE OF
(b) —
DUE TO, OR AS A CONSEQUENCE OF
(c) — | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anencephalic
DUE TO, OR AS A CONSEQUENCE OF
(b) —
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| PREMATURE | | | |
| 19a. DATE OF OPERATION
NA | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-17-87 to 3-17-87, that (I) (we) last saw the deceased alive on 3-17-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Judy C. H. PCHIN, MD | | 22c. DATE SIGNED
3/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Judy C. H. PCHIN, MD | | 22e. ADDRESS | |

| | | | |
|---|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | 23b. DATE
3-19-87 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ALBINA | | | KINDER | | | 03 12 87 | | 4 A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Female | | Caucasian | | 08 16 13 | | 73 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | NORTH CHARLES GEN. HOSP | | | | Retired | | Housework | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. STATE | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | | 13b. STATE | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Joseph Pajtis | | | Agnes Krzyzowski | | | 404 Folcroft Street 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | 215-07-5354 | | Anthony W. Filipiak 22 Dauber Ct. 21207 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) <u>CARCINOMA of LUNG</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>87</u> , to <u>3/12</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | | 22c. DATE SIGNED | |
| <u>Parech C. Patel</u> | | | M.D. | | | | | 3/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| PARECH C. PATEL | | | North CHARLES GENERAL HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 3-16-87 | | St. Stanislaus | | Baltimore City, Md. | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Charles S. Zeiler & Son Inc. | | | | | MAR 13 1987 | | Julia Tindall | | |

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047025 MAR 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07526

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CHARLES F. KING | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 09 87 | | 2b. HOUR
7:00 P.M. | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
07 - 14 - 28 | |
| 6. AGE (IN YEARS (LAST BIRTHDAY))
58 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
CITY | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CONSTRUCTION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALT. CITY | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WALTER KING | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AMANDA THOMAS | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WWII | |
| 17. SOCIAL SECURITY NO.
579322851 | | 18. INFORMANT ADDRESS
ELIZABETH GAINES HENRYTON, MD 21080 | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) PERIPHERAL VASULAR DISEASE | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
03/09 87 03/09 87 | |
| 22. I certify that (I) (this hospital) attended the deceased from 03/09 87 to 03/09 87 , that (I) (we) lost saw the deceased alive on 03/09 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Kuang-Yen Huang M.D. | | DEGREE | | 22c. DATE SIGNED
3/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KUANG-YEN HUANG MD | | 22e. ADDRESS
BON SECOURS Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
03-13-87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST VA | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
GARRISON FOREST BALTIMORE MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
HAIGHT FUNERAL HOME SYKESVILLE, MD | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 12 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Jackson</i> | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



049329 APR - 87

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07527

| | | | | | | | | | |
|--|--|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DOROTHY D KING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 31, 1987 | | 2b. HOUR
A M
10:30 | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 12 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY
Tree | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Hampstead | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4600 Millers Station Rd. 21074 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Driscoll | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Gorman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unkn. | | | 16b. SOCIAL SECURITY NO.
670-26-3812 | | 17. INFORMANT
ADDRESS
Mr. Benjamin King - Same as #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ventilatory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>tracheal erosion</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>pharyngeal Ca</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>1 day</u>
<u>1 month</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>hydrothorax, sepsis, broncho pleural fistula</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>3/9/87</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>pharyngeal Ca</u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/2/87</u> , 19 <u>87</u> , to <u>3/31/87</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3/31/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Steven Frank MD</u> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
<u>3/31/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Steve FRANK</u> | | | | 22e. ADDRESS
<u>601 N Broadway Johns Hopkins Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
4-1-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 03 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randner</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It is to be signed by the funeral director and returned to the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 18 states any injury for which the medical examiner is not available, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician this should be detached for use as the burial-transit permit. Then please remove carbon papers, place in the envelope provided, and return to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

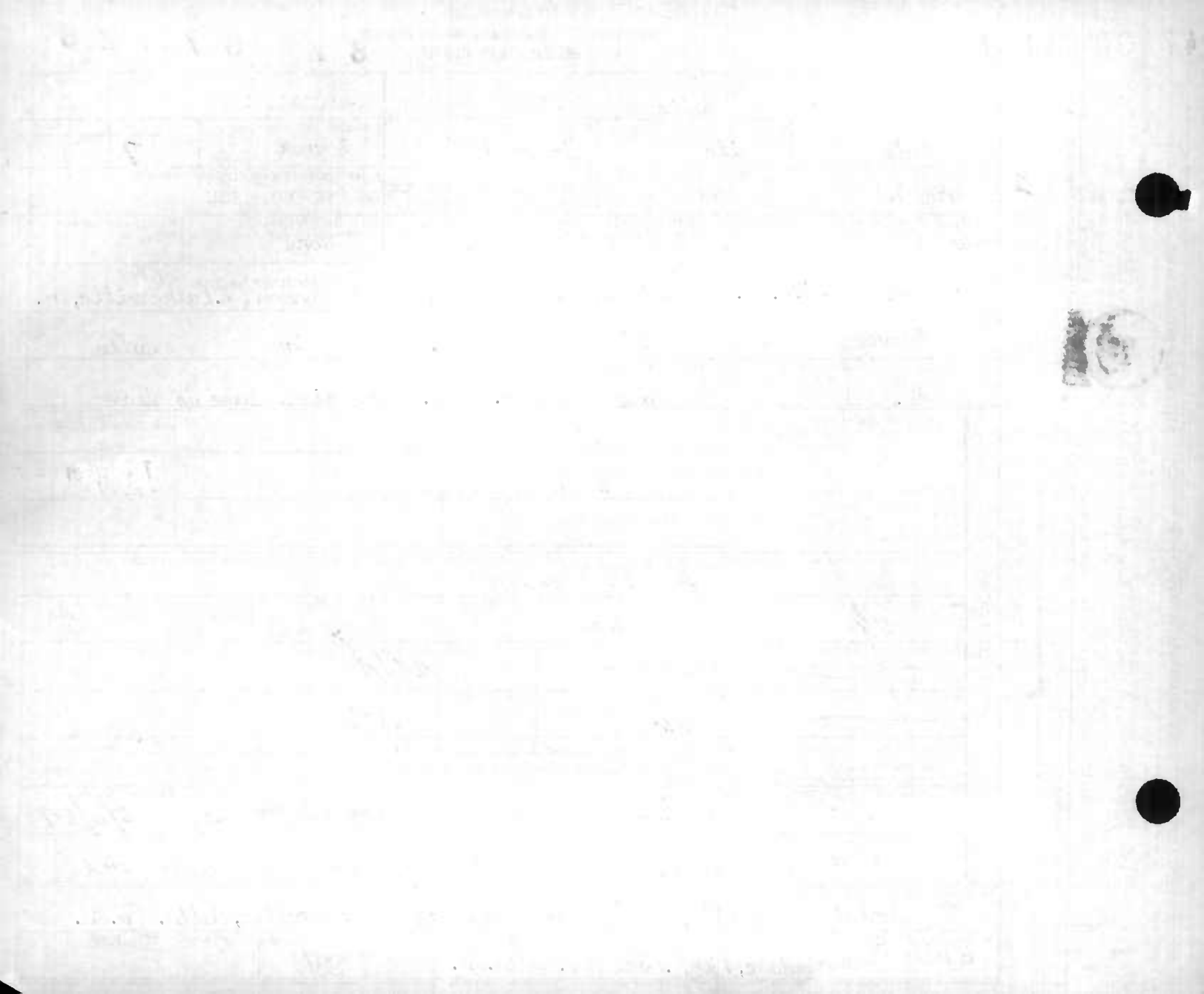
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|---|---|-----------------|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
TYLER | MIDDLE
Nolte | LAST
KIRK | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 11, 1987 | 2b. HOUR P
7:02 M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
3-4-1986 | | 6. AGE (IN YEARS LAST BIRTHDAY)
1 year | 7. IF UNDER 1 YEAR
MONTHS DAYS
9 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
None | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Balto. Co. | 13c. CITY OR TOWN
Lutherville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harvey --- Kirk | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
R. Joy Nolte | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
ADDRESS
Mr. & Mrs. Harvey Kirk. Same as above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardiomycopathy
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
0 Mid.
1 Year on Onys
Birth | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Possible sepsis | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
N/A | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A N/A | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/9 19 87, to 3/11 19 87, that (I) (we) lost
saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
T. A. Digiiovanna | | | | 22c. DATE SIGNED
3/11/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. A. Digiiovanna |
| 22e. ADDRESS
601 N Wolfe St. Balt Md | | | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/13/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville, Balto. Co. Md. |
| 24. FUNERAL DIRECTOR
McCurly Funeral Home, 130 E. Fort Ave. Balto. Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | | 25b. REGISTRAR'S SIGNATURE |

filled in by the funeral director, page 3 should be filed within 72 hours after death.



048204 MAR 20 1987

18a., -22a., G-626, Ty 18a. STATE OF MARYLAND

FOR STATE REGISTRAR #22a., 4/7/87, Gbj. DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO. 07529

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Kenneth Alan Kirschman

2a. DATE KNOWN OF DEATH MONTH DAY YEAR
3/ 14/ 87

2b. DATE OF ESTIMATED DEATH MONTH DAY YEAR
3/ 15/ 87

3. SEX MALE

4. RACE WHITE

5. DATE OF BIRTH MONTH DAY YEAR
DEC. 10, 1948

6. AGE (IN YEARS) LAST BIRTHDAY
38 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
LOUISIANA

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD.

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4315 Underwood Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
INTERIOR DESIGNER-DECORATION

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE
MARYLAND

13b. COUNTY

13c. CITY OR TOWN
BALTIMORE

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS
4315 UNDERWOOD RD. (21218)

14. FATHER'S NAME FIRST MIDDLE LAST
VICTOR F. KIRSCHMAN

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARGERY ALAYNICK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO

16b. SOCIAL SECURITY NO.
439-66-4430

17. INFORMANT ADDRESS
NEW ORLEANS, LA.
VICTOR F. KIRSCHMAN 741 TOPAZ ST. 70124

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Combined drug intoxication
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ PRIMARY CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
? P.M. 3 ? 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
ingestion of drugs

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home

21f. LOCATION STREET CITY OR TOWN COUNTY STATE
4315 Underwood Road, Baltimore, - Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒.

ACTUAL SIGNATURE *Margarita A. Korell* TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 3/16/87

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
REMOVAL-BURIAL

23b. DATE
3/17/87

23c. NAME OF CEMETERY OR CREMATORY
HEBREW REST CEMETERY

23d. LOCATION CITY OR TOWN COUNTY
NEW ORLEANS LOUISIANA

24. FUNERAL DIRECTOR NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO, MD 21215

25a. DATE REC'D. BY REGISTRAR
MAR 24 1987

25b. REGISTRAR'S SIGNATURE
Sol Levinson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver certain papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07530 | |
|--|--|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Catherine Klamer | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 12 87 | | | 7b. HOUR
8:15P M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 15 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1708 Letitia Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Data Processor | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1708 Letitia Ave. 21230 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Klamer | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Priessman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
216-44-3513 | | 17. INFORMANT ADDRESS
Margaret Borgfeldt 1225 Circle Dr. 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic squamous cell carcinoma of the cervix
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Stroke | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/20/87, 19 87, to 19 87, that (I) (we) last saw the deceased alive on 10/20/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Barahona | | | | DEGREE
MD | | | | 22c. DATE SIGNED
3/13/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Barahona, Leonel | | | | 22e. ADDRESS
Leeds Federal Building | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
John Swiden-Randall | | | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07532

| | | | | | | |
|---|--|--|--|---|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
VINCENT J. KLIMA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 16, 1987 | | 2b. HOUR
12:44 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 11, 1904 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home Hospital | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Iron Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | | 13a. STREET ADDRESS / ZIP CODE
6812 Belclare Road 21222 | | |
| 13b. STATE
Maryland | | 13c. COUNTY
Baltimore | | 13d. CITY OR TOWN
Dundalk | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Klima | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Not Known | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b. SOCIAL SECURITY NO.
216-10-4081 | | 17. INFORMANT
Lillian Lane | | ADDRESS
3101 Shortway 21222 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(c) PULMONARY EDEMA, REFRACTORY
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from MARCH 15 , 19 87 , to MARCH 16 , 19 87 that (I) (we) last saw the deceased alive on MARCH 16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<i>Alan Rosenbloom MD.</i> DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | |
| 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN ROSENBLUM, M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD 21231 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-19-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Ht. of Jesus | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Duda-Ruck Funeral Home of Dundalk
7922 Wise Ave. Dundalk, MD 21222 | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
<i>John D. Anderson</i> | | | | | | |

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of the death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other circumstances, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|--|---|--|
| 1- FOR
STATE
REGISTRAR | | 8 REG. NO. | | 07 | | 5 | | 1 | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
HENRY Julius KLEINHENN | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 11, 1987 | | | 3. HOUR MIN.
9:15 P.M. | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
8 22 91 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY
Amer. Smelt. R. | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3313 Foster Avenue 21224 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Julius Kleinhenn | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Katherine Hoffman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
212-10-2151 | | 17 INFORMANT ADDRESS
Regina C. Biggs 763 Hawthorne Rd. 21090 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>KIDNEY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
CONGESTIVE CONGESTIVE HEART FAIRLURE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 10</u> , 19 <u>87</u> , to <u>MARCH 11</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>MARCH 11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
A. P. Nazemi M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/11/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ATAOLLAH NAZEMI MD. | | | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3-14-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dundalk Balto. Co., Md. | | | | |
| 24 FUNERAL DIRECTOR
NAME Charles S. Zeiler & Son Inc. ADDRESS 901 S. Conkling St. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Lindner | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM JOSEPH KLINEFELTER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 31, 1987 | | | 2b. HOUR
2 P M | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
July 18, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 74 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
506 Rose Hill Terrace | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel Co. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William J. Klinefelter | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Jennie Fielding Bosson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-10-4821 | | 17. INFORMANT ADDRESS
Kenneth Square 434
Genevieve K. Brady Balto., Md. 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe Coronary Artery Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes
15 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Arterial Sclerosis, Hypertension, Left Ventricular Dysfunction</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>62</u> , to <u>3/31</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
William Benson Jr. M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William P. Benson, Jr. M.D. | | | | | 22e. ADDRESS
3506 N. Calvert St. Baltimore, Md. 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
April 1, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 7 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia T. [Signature] | | | |

4/10

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46585 MAR 11 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1 - STATE
REGISTRAR

Sophia

L.

Knauff

87 REG. NO.

07534

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SOPHIA KNAUFF | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03/06/87 | | | 2b. HOUR
8:37 P.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 19 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Textile Worker | |
| 13a. STATE
MD | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
2518 Westchester Avenue 21043 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Leppert | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ann Oskie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
214-12-2174 | | 17. INFORMANT
Derwood, James E. Knauff 5829 Rolling Dr. 20855 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POSSIBLE Acute MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 IMMED. YEARS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-14-87 to 03-06-87 , that (I) (we) lost
saw the deceased alive on 03-06-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
B. ZAW-WIN DEGREE | | | | 22c. DATE SIGNED
3-7-87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. ZAW-WIN | |
| 22e. ADDRESS
LEVINDALE GEM + TRC | | | | 22f. ADDRESS
BALTO 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
03/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Balto., MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Catonville, MD 21228
MacNabb Funeral Home 301 Frederick Rd. | | | | 25. DATE REC'D BY REGISTRAR
MAR 10 1987 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and consecutively filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

BP _____

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W. J. Kimball
12-1-00

047505 MAR 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07535

| | | | | | |
|--|---|---|--|---|-------------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jesse (NMN) Knight | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 11, 1987 | | 2b. HOUR
11 40 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 14, 1987 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
25 | IF UNDER 1 YEAR
IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NA | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
Severn | 13c. STREET ADDRESS / ZIP CODE
1614 SEVERN Road 21144 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
(Unknown) | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lisa Marlene Knight | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Lisa M. Knight Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>RENAL INSUFFICIENCY</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>INTERUPTED AORTIC ARCH</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>ATRIO-VENTRICULAR CANAL TRACHEO-ESOPHAGEAL FISTULA (REPAIRED) GRADE IV I.V.H.</u> | | | | | |
| 19a. DATE OF OPERATION
2/16/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
TRACHEO-ESOPHAGEAL FISTULA
HYPOPLASTIC AORTIC ARCH; PDA | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2/15/87</u> 19 <u>87</u> , to <u>3/11</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>3/11</u> 19 <u>87</u> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael E. Smith | | DEGREE
MD | | 22c. DATE SIGNED
3/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Mar 13, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
BALTIMORE | | STATE
Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | ADDRESS
Glen Burnie, Maryland | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

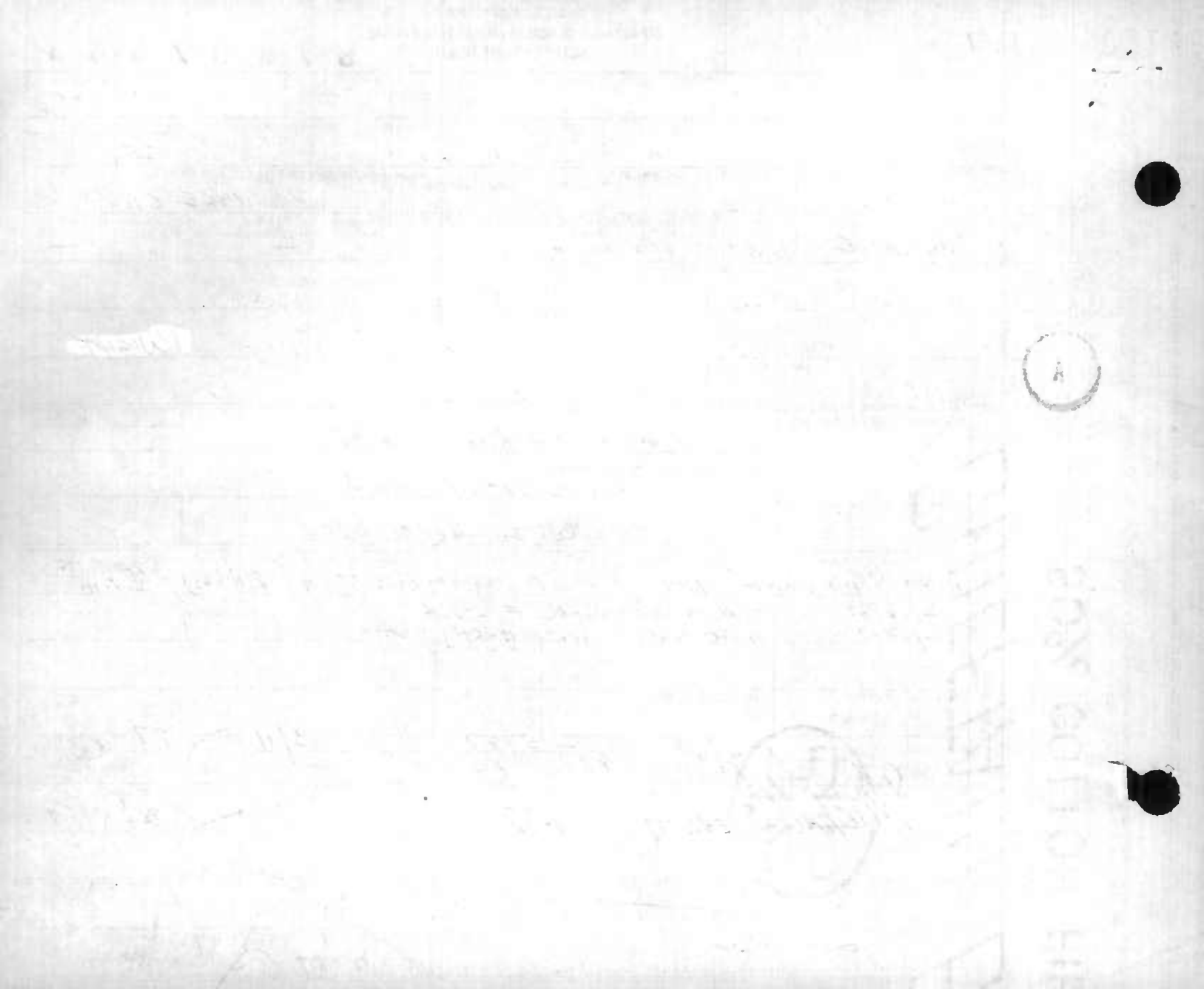
MEDICAL CERTIFICATION

TO HOSPITAL OR DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove certain pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07536 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
WINFORD F. KOFESKEY | | | | 3 21 87 | | | |
| 3. SEX
MALE | | 4. RACE
CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR
10-30-08 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WINFORD P KOFESKEY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CHRISTINA FRAZIER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
213-01-4180 | |
| 17. INFORMANT ADDRESS
MRS GERTRUDE KOKKONEN | | 7123 CRESTSHIRE Rd | | 2122 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE UPPER GASTROINTESTINAL BLEEDING
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION
NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-14-87, 19, to 3-21, 19 87, that (I) (we) last saw the deceased alive on 3-21, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
George K. Thomas | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE K. THOMAS | | | | 22e. ADDRESS
CHURCH HOSPITAL
100 N BROADWAY BALTIMORE, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART & JESUS | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE Co. MD | |
| 24. FUNERAL DIRECTOR NAME
KACZDROWSKI Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
Rundak | |

10-10-10

10-10-10

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10-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove cover slip. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

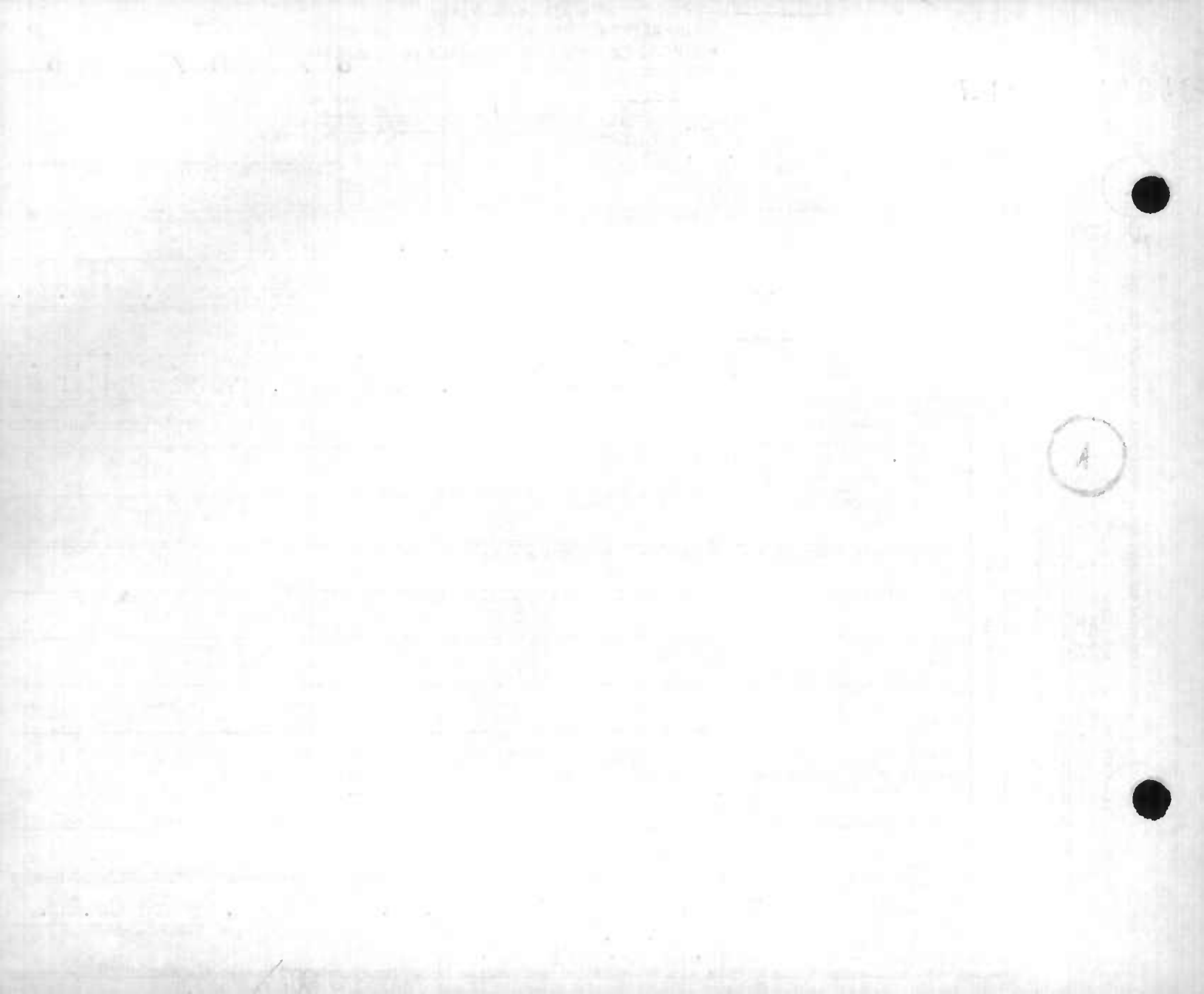
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR
CHARLOTTE F. KONE | | 87 REG. NO. 07531 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Charlotte F Kone | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 1 87 | | | | | | | |
| 3 SEX
Female | | 4 RACE
White | | | | | | | |
| 5 DATE OF BIRTH
MONTH DAY YEAR
August 6, 1931 | | 6 AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deacon Hospital & Medical Center | | | | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | | | | | | |
| 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 13e. STREET ADDRESS / ZIP CODE
6017 Falkirk Road 21239 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles L. Kone | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lula Zink | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-74-3367 | | | | | | | |
| 17. INFORMANT
Walter D. Kone | | ADDRESS
614 E. 34th Street 21218 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration of stomach contents with pneumonia
911
DUE TO, OR AS A CONSEQUENCE OF
(b) Stress-related hemorrhagic gastritis
DUE TO, OR AS A CONSEQUENCE OF
(c) Anoxic encephalopathy.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
Chronic obstructive pulmonary disease; Down's Syndrome. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 18 19 87, to March 1 19 87, that (I) (we) last saw the deceased alive on March 1 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
George J. Kone, M.D. | | 22c. DATE SIGNED
March 2, 1987 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George J. Kone, M.D. | | 22e. ADDRESS
600 Light St. Balt. Md. 21230. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
March 3, 1987 | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Sherwood Church Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Balto., Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR
MAR 04 1987 | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
J. J. J. J. | | | | | | | | | |

100% COTTON FIBER



WASH

[Faint, illegible text and markings covering the majority of the page, likely bleed-through from the reverse side.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|----------------------|--|--|
| 1. FOR
STATE
REGISTRAR | | 8 REG. NO. 07539 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BRIGID VERONICA KORNICK | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 8, 1987 | | | 2b. HOUR
11:00 AM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 22, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3021 Royston Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Patrick Owens | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Callaghan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-12-7185 | | 17. INFORMANT
ADDRESS 21214
George Kornick, 3021 Royston Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) ASCVD - DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Unstable Angina - CHF
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 8/23/87 to Mar 8/87, that (I) (we) last saw the deceased alive on 3/5/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
Donald W. Mintzer, M.D. | | | | DEGREE AND
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Mar. 9, 1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald W. Mintzer, M.D. | | | | 22e. ADDRESS
3009 Evergreen Ave. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar. 11, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
ROBERT C. ALTENBURG FUNERAL HOME, INC.
Balt., Md. 21214 6009 Harford Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rodner | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

8 REC NO

07

| | | | | | | |
|---|--|---|--|--|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Raymond J Kosmicky | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 8 87 | | 2b. HOUR
2:25 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 30 1925 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven VAMC | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
228 S. Chester St. 21231 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Phillip Kosmicky | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Chlopicki | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT ADDRESS
Anne R. Kosmicky 228 S. Chester St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Prolonged Hypotension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Infected Aortic Graft
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 minutes
16 hours
3 1/2 months | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Renal Failure | | | | | | |
| 19a. DATE OF OPERATION
10/31/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic valve occlusive disease | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26 , 19 87 , to 3/8 , 19 87 , that (I) (we) last saw the deceased alive on 3/8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
S. Marks | | DEGREE
MD | | 22c. DATE SIGNED
3/18/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. MARKS | | 22e. ADDRESS
3900 Loch Raven Blvd, VA Med. Center | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-12-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JOHN M. WEBER & SONS INC. 401 S. CHESTER ST. | | 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. (IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.)

UNITED STATES



NOV 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use on the burial transit permit. Then please remove carbon copies of Pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial. Transmission of this certificate to the State Dept. of Health and Mental Hygiene is required. (IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.)

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

8 REG. NO. 07541
2a. DATE OF DEATH MONTH DAY YEAR 3 13 87 2 P M

| | | | |
|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Frank Kowalski | | 2b. DATE OF DEATH MONTH DAY YEAR 3 13 87 2 P M | |
| 3. SEX
Male | 4. RACE
Cauc. White | 5. DATE OF BIRTH MONTH DAY YEAR 10 27 05 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 12b. KIND OF BUSINESS OR INDUSTRY
Rigger Form. Shipping | |
| 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Ellicott | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frank Kowalski | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Victoria Unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
215-07-4175 | |
| 17. INFORMANT ADDRESS
Frances Kowalski 3020 Oak Green Cir | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic Bladder CA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebrovascular accident</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|--|---|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
IN <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

| | | |
|---|--|-----------------------------|
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22c. DATE SIGNED
3/13/87 |
| 22b. SIGNATURE
Peter H. Park, M.D. | | 22e. ADDRESS |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter H. Park, M.D. | | 22f. ADDRESS |

| | | | |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
3/17/87 | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. |
| 24. FUNERAL DIRECTOR NAME
B. Dabrowski & Son 2818 E. Baltimore St. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 16 1987 | |

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MARY
<i>Elena</i> | | MIDDLE ELENA | | LAST KOZLOVSKY
<i>Kozlovsky</i> | | 2a. DATE OF DEATH MONTH DAY YEAR
3-16-87 | | 2b. HOUR
11:42 AM | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
6 8 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
900 S. East St. 21224 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Wenceslaus Kozlovsky | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Catherine Baroch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT ADDRESS
Sr. Mary Fitzgerald 900 S. East St. 21224 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction & Ventricular Fibrillation</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>HRT. failure & Ch. Lung Disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial HRT. Disease</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/14/87, 1987, to 3/16/87, 1987, that (I) (we) lost
saw the deceased alive on 3/15/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Michael F. Plott</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael F. Plott | | | | 22e. ADDRESS
Mercy Hosp. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-19-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Villa Maria | | 23d. LOCATION
CITY OR TOWN
Glen Arm | | COUNTY
Balto | | STATE
Md. | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home | | | | | | ADDRESS
6500 York Road 21212 | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

MAR 18 1987

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1122 JOURNAL OF POST KEYNESIAN ECONOMICS



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DHMH - 16 60M 7/84
(VRA 15, 4)

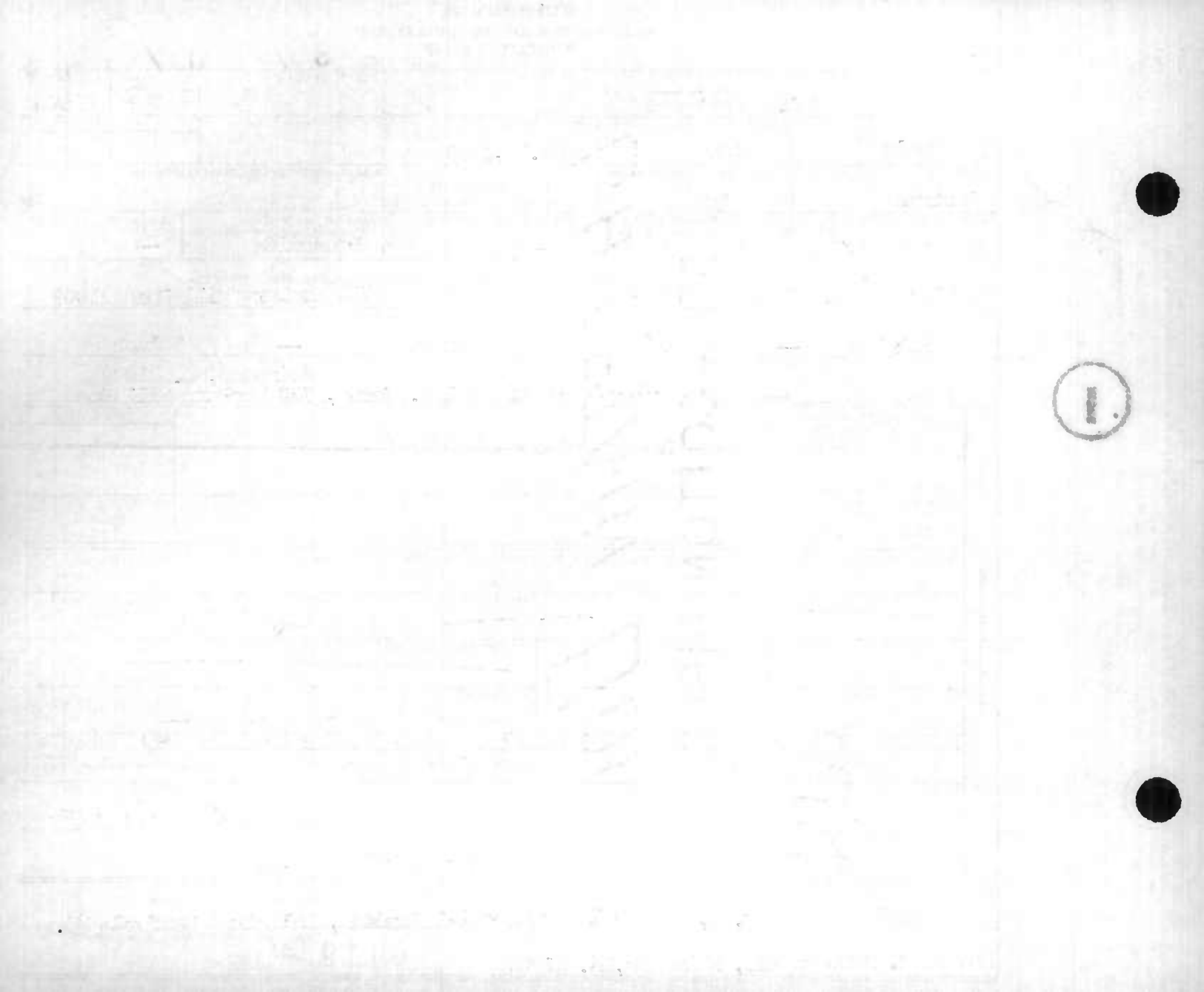
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ANNA CECILIA KOZUB | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 17 87 | | | | |
| 3. SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 19, 1899 | | 6 AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | 2b. HOUR
0535 AM | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Austria | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY
-- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Abingdon | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Nicholas -- Stec | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Barbara -- Baluch | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no -- | | | | 16b. SOCIAL SECURITY NO.
213-18-6551-A | | 17. INFORMANT ADDRESS
Michael J. Kozub, 730 Hookers Mill Road | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Aortic Stenosis
DUE TO, OR AS A CONSEQUENCE OF (c) --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3/10/1987, to 3/17/1987, that (I) (we) last saw the deceased alive on 3/17/1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
S. O. Trerotola MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/17/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. O. Trerotola MD | | | 22e ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Mar. 20, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Bel Air Memorial Gardens, Bel Air | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Harford Md. | | |
| 24 FUNERAL DIRECTOR NAME
Howard K. McComas III, Abingdon, Md. 21009 | | | 25a DATE REC'D. BY REGISTRAR
MAR 19 1987 | | 25b REGISTRAR'S SIGNATURE | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|--|---|--|--|-----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| NORSIE | | LEWIS | | KRAM | | 03/09/87 | | 1110 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Female | | White | | MONTH DAY YEAR
08 09 04 | | 82 YRS. | | IF UNDER 74 HRS.
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | USA | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE CITY | | ST. AGNES HOSPITAL | | | | Bookkeeper | | banking | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13b. STATE | | | | | 13c. CITY OR TOWN | | | | |
| Maryland | | | | | Elkridge | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | |
| Henry D. Lewis | | | | | Sarah Mathews | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| NO | | 220-05-9102 | | Kelso E. Phillips 5968 Forest Ct. 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) to | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| | | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/7/87, to 3/9/87, that (I) (we) last saw the deceased alive on 3/9/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | |
| Bulent Atac | | | MD | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| Bulent Atac | | | 900 Caton Ave. Baltimore City, Md. 21229 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Burial | | | 03/13/87 | | Cape Charles Cemetery | | Cape Charles N. Hampton Va. | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS
Ambrose Funeral Home 1328 Sulphur Spr. Rd. | | | 21227 | | | MAR 12 1987 Julia Swider-Randall | | | |

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1911

[Faint, illegible text, likely bleed-through from the reverse side of the page]

1000 S. 1st N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

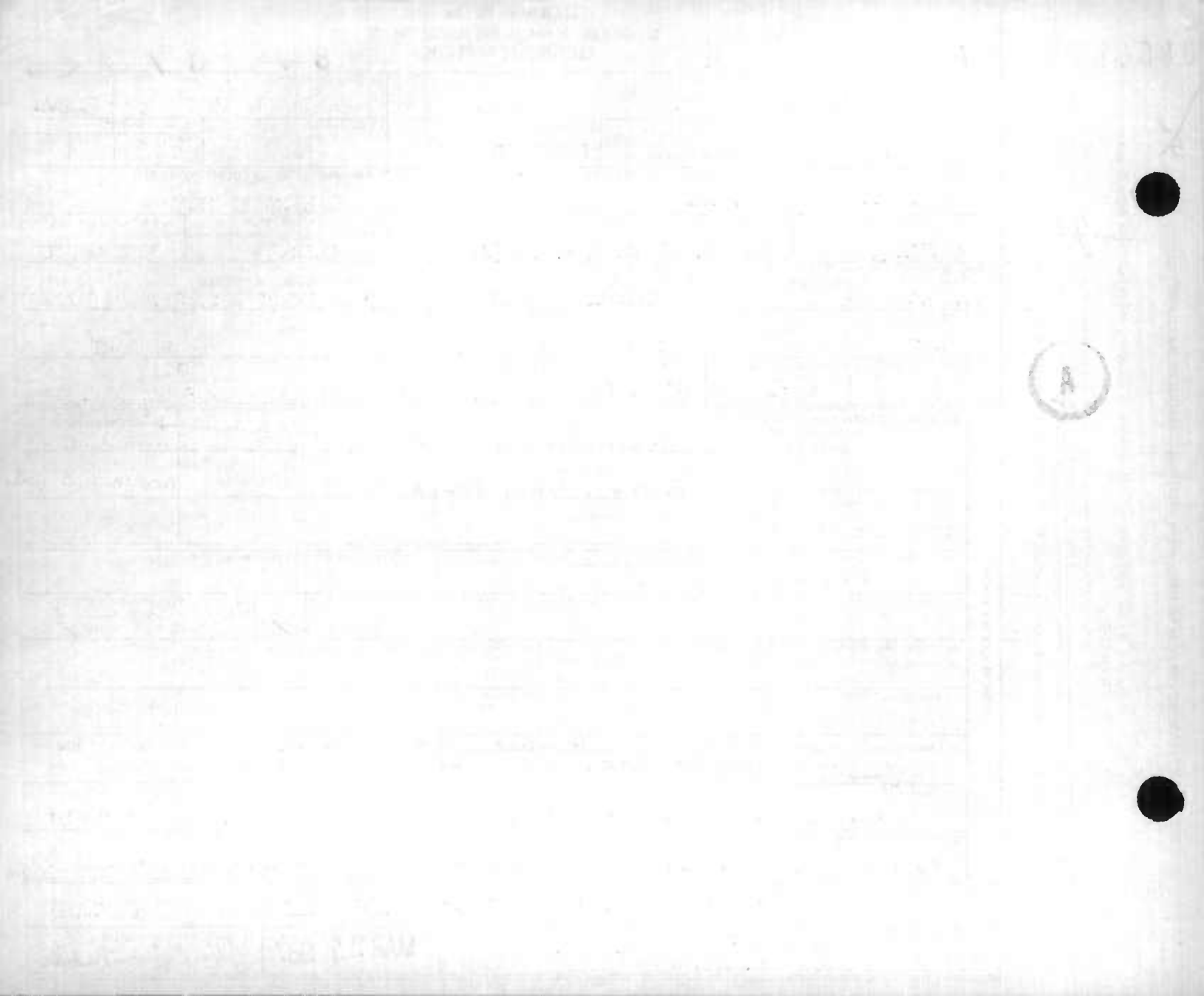
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the container for the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| FOR STATE REGISTRAR | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | CERTIFICATE OF DEATH | | REC. NO. 07545 | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
BERNARD E. KRAMER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 24, 1987 | | 2b. HOUR
3:30A _M | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
DECEMBER 25, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3806 FORDS LA., APT. 204 (21215) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
POST OFFICE | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3806 FORDS LA., APT. 204 (21215) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JACOB KRAMER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MOLLY ELKHART | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
WWII-ARMY | | 17. INFORMANT ADDRESS
MRS. SALLY KRAMER 3806 FORDS LA., APT. 204 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>more than 5 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Parkinson's Disease</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December</u> , 19 <u>86</u> , to <u>March</u> , 19 <u>87</u> , that (II) <input checked="" type="checkbox"/> last saw the deceased alive on <u>March 23</u> , 19 <u>87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> we did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Christine J. Bell-Lafferman</u> | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHRISTINE J. BELL-LAFFERMAN MD | | | | 22e. ADDRESS
Veterans Administration Federal Building Baltimore Md 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY
ADATH YESHURUN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |

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047057 MAR 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

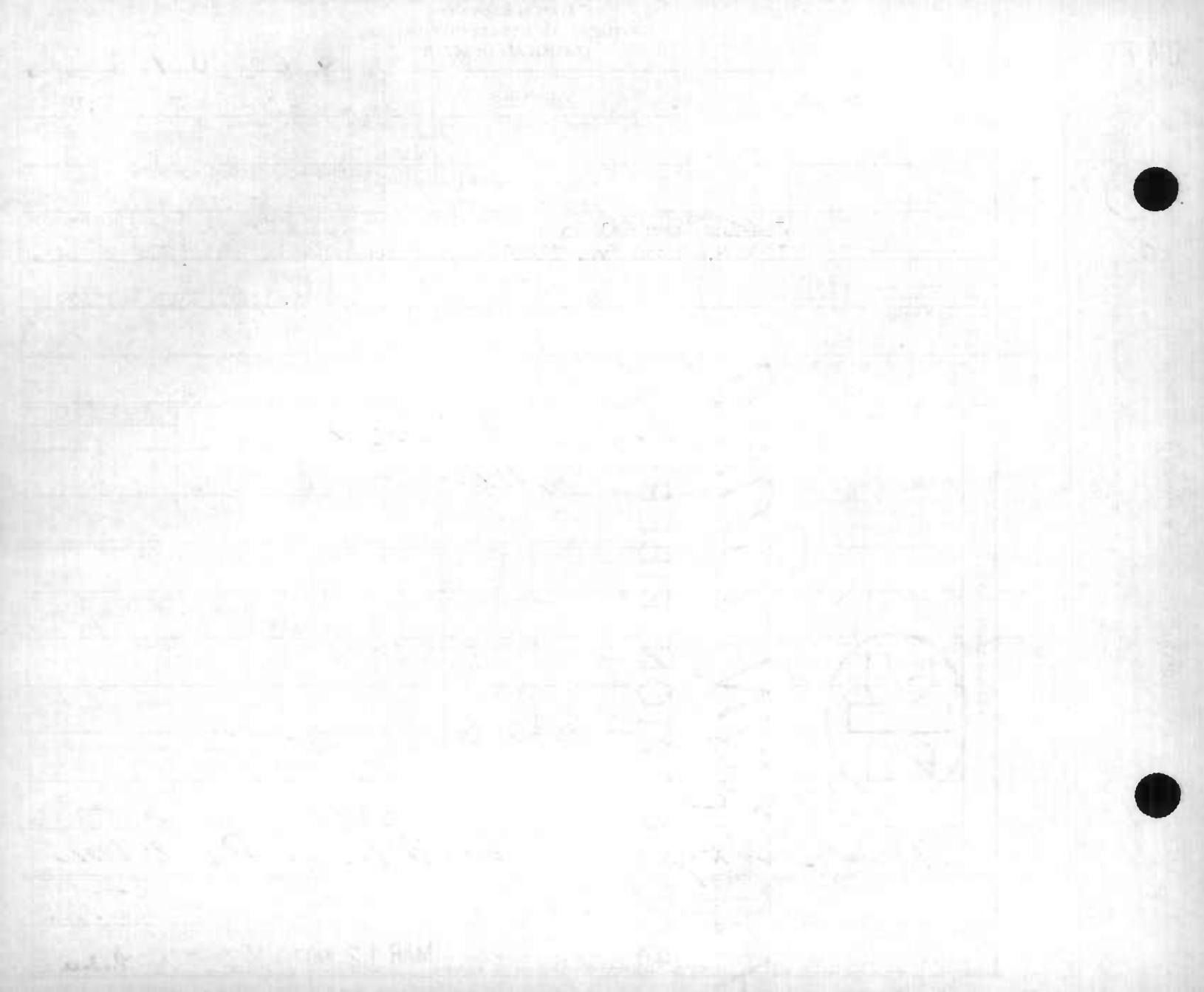
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified) must be notified.

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07546

| | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
August H. Kuhfuss | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 - 10 - 87 | | | 2b. HOUR
4:15 P _M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOVEMBER 30, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Jenkins Memorial Home
1000 S. Caton Ave. 21229 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY
CCB | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
KARL H. KUHFUSS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERTHA WILMERING | | | 13e. STREET ADDRESS
1000 S. CATON AVENUE 21229 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
WW2 | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW2 | | 17. INFORMANT
ADDRESS
NURSING HOME RECORDS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-3-82</u> 19 <u>82</u> to <u>3-10-87</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3-7-87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>George D. X. Jr.</u> | | | DEGREE | | | 22c. DATE SIGNED
<u>3/11/87</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>George D. X. Jr.</u> | | | 22e. ADDRESS
<u>550 - Wilkes Dr - Belton</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
MARCH 13, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. VETERANS CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GARRISON FOREST BALTO. MD. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 12 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>P. J. ...</u> | | |

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FOR
STATE OF
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REC NO.

07547

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Rachael L. Lafferty | | | 2a. DATE OF DEATH
MONTH 3 DAY 6 YEAR 87 2b. HOUR 10:25 ^A _M | | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH 4 DAY 21 YEAR 01 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) Delaware | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lafayette Square Nsg Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Soc. Secty. & Insurance |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
21201 524 N. Charles St | |
| 14. FATHER'S NAME
FIRST William MIDDLE H. LAST Lafferty | | 15. MOTHER'S MAIDEN NAME
FIRST Evelyn MIDDLE Collins LAST Collins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
212-07-3306 | | 17. INFORMANT
Donald Burris ADDRESS 453 W. Lewis Shore Rd. Elkton, Md. 21921 | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Angiogram | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

| | | | |
|---|---|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
2. Hemiparesis - Cerebral A. | | | |
| 19a. DATE OF OPERATION
3/15/87 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
2. Hemiparesis - Cerebral A. | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15/87 to 3/6/87 , that (I) (we) lost
saw the deceased alive on 3/5/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Mohammed Aslam | | DEGREE
M.D. | 22c. DATE SIGNED
3/6/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Mohammed Aslam | | 22e. ADDRESS
300 Armory Place, Suite 3L, Bal. Md. 21201 | |

| | | | |
|--|---------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE 11 | 23c. NAME OF CEMETERY OR CREMATORY
March 11, 1987 Odd Fellows Cemetery | 23d. LOCATION
CITY OR TOWN Camden-Wyoming, Kent Co. Delaware |
| 24. FUNERAL DIRECTOR
NAME Mitchell Wiedefeld Home Inc. ADDRESS 6500 York Rd. Bal. Md. | | 25a. DATE REC'D. BY REGISTRAR MAR 10 1987 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Let

Page 11-1

• Vol. 12, No. 200 2007

048795

1- FOR 87
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 0 7 5 4 8
REG. NO

| | | | | | |
|--|-----------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Florence S. Lang | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 30 87 | | 2b. HOUR
MIN.
6 25 P.M. | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
2-25-1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 yrs. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Sebastian LeGano | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Unknown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
070-18-3696 | | 17. INFORMANT ADDRESS
Robert Lang 3833 Elmley Avenue 21213 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
DAYS |
| DUE TO, OR AS A CONSEQUENCE OF (b) PARKINSON'S DISEASE | | | | | YEARS |
| DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS | | | | | YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
History of Cerebrovascular Accident | | | | | |
| 19a. DATE OF OPERATION
3/25 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 87 , to 3/30 , 19 87 , that (I) (we) last saw the deceased alive on 3/30 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W. W. Todd | | DEGREE
MD | | 22c. DATE SIGNED
3/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Nevin W. Todd | | 22e. ADDRESS
301 St. Paul Place Balt. MD 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-3-87 | | 23c. NAME OF CEMETERY OR CREMATORY
OakLawn Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR
Schimmek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | 25a. DATE REC'D BY REGISTRAR
MAR 31 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07549

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) aka FIRST Mary Frances F. Lange | | MIDDLE Farrar | | LAST Lange | | 2a. DATE OF DEATH
MONTH 3 DAY 18 YEAR 87 | | 2b. HOUR
A M | |
| 1. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 7 DAY 1 YEAR 36 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Rep. | | 12b. KIND OF BUSINESS OR INDUSTRY
Electronic Components | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
1922 Greengage Road 21207 | | | |
| 14. FATHER'S NAME
FIRST Winfred MIDDLE LAST Farrar | | 15. MOTHER'S MAIDEN NAME
FIRST Katherine MIDDLE LAST Hackett | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-32-3884 | | 17. INFORMANT ADDRESS
Melvin W. Lange Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Widely spread non-small cell Carcinoma | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Months
Year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12 , 19 87 , to 3/18 , 19 87 , that (I) (we) last saw the deceased alive on 3/18 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Paul Wansley MD P. Warshawski | | DEGREE
Resident | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/18/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Aron Berkman MD Paul Wansley MD | | 22e. ADDRESS
South Baltimore General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
Baltimore COUNTY A.A. STATE MD | | | |
| 24. FUNERAL DIRECTOR
George J. Gonce | | 4001 Ritchie Hgwy Balto Md | | 25a. DATE RECD BY REGISTRAR
MAR 20 1987 | | 25b. REGISTRAR'S SIGNATURE
John R. Rader | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified at once.

047242

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07550

| | | | | | | | | |
|---|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WARDELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 8, 1987 | | | 3. HOUR
1:45 PM | | |
| 3. SEX
Male | | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 10 41 | | 6. AGE (IN YEARS LAST BIRTHDAY)
45 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Miss. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Welder | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Langham | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | 13e. STREET ADDRESS / ZIP CODE
125 N. Colvin St. 21213 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
1958-1968 428-76-5054 | | 17. INFORMANT ADDRESS
Sandra White 1225 Cavindish Way 21224 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LUNG CANCER WITH BRAIN METASTASES
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 2, 1987 , to MARCH 8, 1987 , that (I) (we) lost saw the deceased alive on MARCH 8, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<i>Paul Gormley</i> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/8/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL GORMLEY, M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTO., MD. 21231 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-12-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mill, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
William C. Brown 1206-08 W. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>John F...</i> | | |

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OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27

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(8)

048665 MAR 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8-7 REG. NO. 07551

| | | | | | | | | | | |
|--|--|---|---|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ERIC LARSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03-26-87 | | 2b. HOUR
10¹⁰ A M | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
08-28-1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALES MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. STORE | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
707 E. LAKE AVE. 21212 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANDREW LARSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SELMA HESSLER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
325-05-2677 | | 17. INFORMANT
SHIRLEY ENGLISH | | ADDRESS
SAME | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIOPULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b) **CACHEXIA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **LUNG CANCER**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 3-2 , 19 87 , to 3-26 , 19 87 , that (1) (we) last saw the deceased alive on 3-26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
D. Hooper, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-26-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. HOOPER, M.D. | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL, BALTIMORE | | | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal-Burial | | 23b. DATE
3-27-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Elmlawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elmhurst Ill. | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co., Balto., Md. | | | | 4905 York Rd.
ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper and file in my file. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the reason must be notified of one.

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LIBRARY

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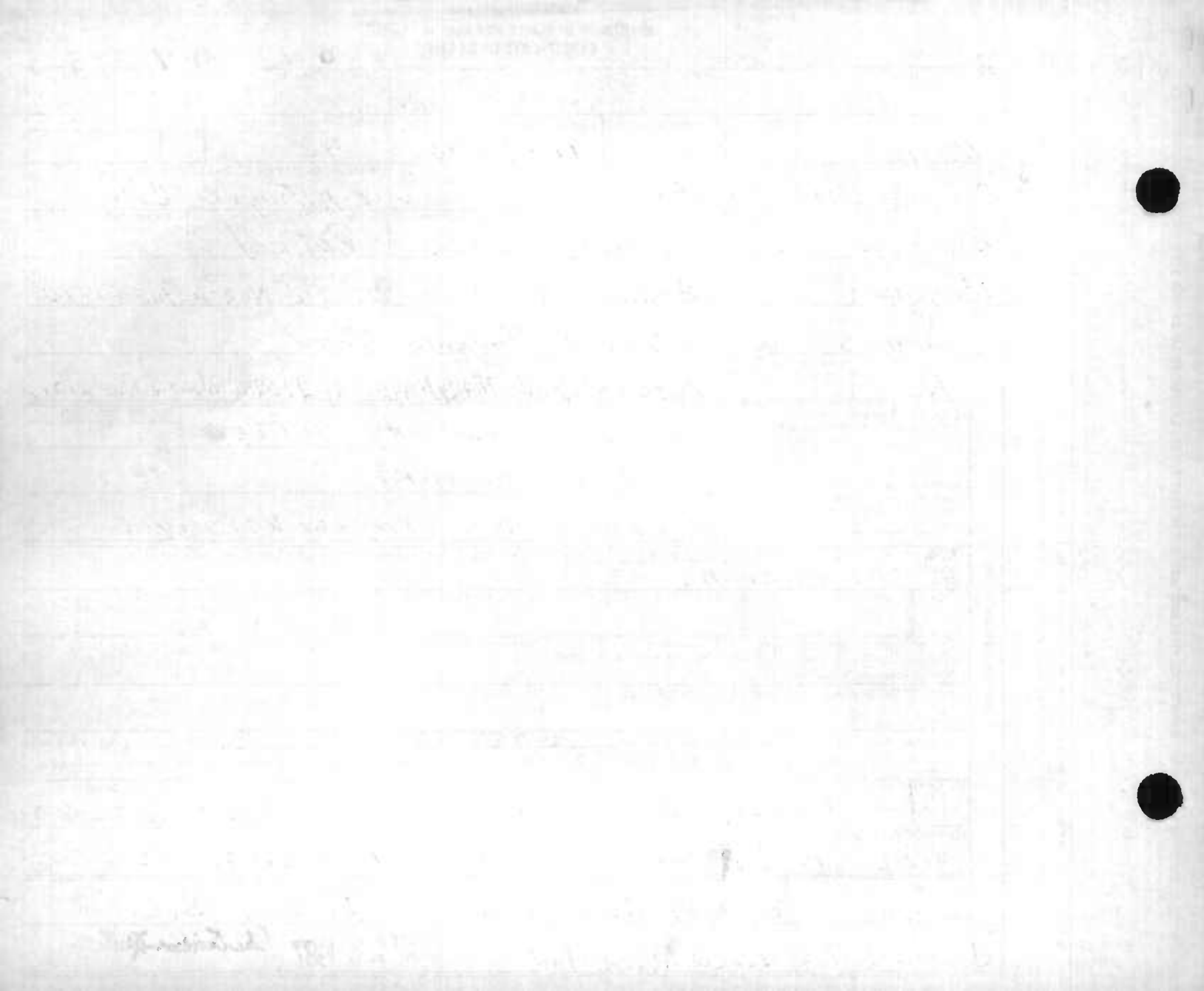
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|------------------------------------|--|--|--|--|
| <div> <div>FOR
1- STATE
REGISTRAR</div> <div>8 REC. NO. 07553</div> </div> | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2. DATE OF DEATH | | | 3. HOUR | | | |
| JAMES W. LEACH JR. | | | 3-22-87 | | | 3:05 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | Col. 2 | | 11-7-40 | | 46 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| SOUTH CAROLINA | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | LIBERTY MED. CENTER | | | | RETIRED | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | | | BALTIMORE | | | | 2202 W. NORTH AVE 21216 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| JAMES W. LEACH SR. | | | THELMA TATE | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| NO | | | 248 625269 | | | MRS MARY MAY BERRY 2202 W. NORTH AVE 21216 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>HEPATIC FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>CIRRHOSIS OF LIVER due to ALCOHOL ABUSE</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>SEVERE ANEMIA</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-28-1987</u> to <u>3-22-1987</u> , that (I) (we) last saw the deceased alive on <u>3-22-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | |
| <u>Anil N. Raiker</u> | | | MD | | | 3-22-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| ANIL N. RAIKER | | | LIBERTY MEDICAL CENTER | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 3-27-87 | | GAFFNEY MEM CEM | | GAFFNEY S.C. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE | | | |
| JOSEPH L. RUSS 2232 W. NORTH AVE | | | | | | MAR 23 1987 <u>John Gordon Russell</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07554 | |
|---|--|--|--|---|--|--|--|---|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Annie Belle Lee</i> | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 7 87</i> | | 2b. HOUR
<i>7:20 AM</i> | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 24 00</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>86</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>South Carolina</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Denton Hosp + Medical Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>BALTO.</i> | | 13c. CITY OR TOWN
<i>BALTO.</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>4019 BATEMAN 21216</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>James Byrd</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Abbie Jacob</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>250-14-7561A</i> | | 17. INFORMANT ADDRESS
<i>MARGARET DUPREE 4019 BATEMAN</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Intermittent Cardiac Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Coronary Artery Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Diabetic Mellitus, Recent</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>years</i>
<i>years</i>
<i>months</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a)
<i>Bilateral Abre Knee prosthesis, Diabetic Ulcers</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>Market 37</i> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>January 7, 1987</i> , to <i>March 6, 1987</i> , that (I) (we) last saw the deceased alive on <i>March 7, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Rolando V. Gocomo</i> | | | | DEGREE
<i>MD</i> | | | | 22c. DATE SIGNED
<i>3-7-87</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Rolando V. Gocomo</i> | | | | 22e. ADDRESS
<i>Denton Hospital Medical Center</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>BURIAL</i> | | 23b. DATE
<i>3/12/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>MT. AUBURN</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTO. MD</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>LERÖY O. DYFTT 4500 LIBERTY HEIGHTS</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 09 1987</i> | | 25. REGISTRAR'S SIGNATURE
<i>Julia Sanders-Randall</i> | | | | | |

BP

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. This page requires transportation. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other significant event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|---|-------|---|-------|--|--|-----------------------------------|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Hester | | Ann | Lee | March | | 1 | 1987 | 1:35 | P.M. | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | Black | | 04 08 1907 | | 79 YRS. | | MONTHS | DAYS | HOURS | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Virginia | U. S. A. | | | | Baltimore, City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | Maryland General Hospital | | | | Homemaker | | Home | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | 13e. STREET ADDRESS / ZIP CODE | |
| Isaac | | | | | Davis | | | | | Mary | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| No. | | | | | 219-32-2625 | | Esther D. Lee | | Baltimore, Maryland
718 N. Carrollton Ave. 21217 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary Heart Disease</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Metastatic Breast Carcinoma</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>February 27</u> , 19 <u>87</u> , to <u>March 1</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on <u>March 1</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I/we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Tzong Hwang</u> | | | | | | | | <u>3/1/87</u> | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| <u>Tzong Hwang</u> | | | | | | c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | | 3/05/1987 | | Arbutus Memorial Park | | Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | | | MAR 03 1987 | | <u>Julia Anderson-Randall</u> | | | |

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12/10/71

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MAR 03 1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and filed, the funeral director must completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07556 | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT R. LEE, JR. | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 3, 1987 | | 2b. HOUR
1:32 M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
9-18-1948 | | 6. AGE (IN YEARS LAST BIRTHDAY)
38 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington DC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)
Construction | 12b. KIND OF BUSINESS OR INDUSTRY
Contracting | |
| 13a. STATE
Md | | | 13b. COUNTY
AACo. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Robert R. Lee Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Gladys Wells | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-46-7104 | | 17. INFORMANT ADDRESS
Nancy L. Lee Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Failed Heart on Left Vent. Assist dev.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Massive Anterior MI.</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 min
10 weeks
12 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary Artery Disease</u> | | | | | |
| 19a. DATE OF OPERATION
<u>3/3/87</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Massive Ant MI. ECHF</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>86</u> , to <u>3/3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>3/3/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>C Stone</u> | | 22e. ADDRESS
<u>600 N. WOLFE ST. BALTO. MD. 21205</u>
<u>John Hopkins Hosp</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-5-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Nichols Bethel | |
| 23d. LOCATION CITY OR TOWN
Odonton | | COUNTY
AACo. | | STATE
Md. | |
| 24. FUNERAL DIRECTOR NAME
Hardesty Funeral Home | | ADDRESS
Md. Annapolis | | 25a. DATE REC'D. BY REGISTRAR
MAR 05 1987 | |
| 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | | | |

BP



100-1-155-1

8-1-55

MAILED 1955

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

87 REG. NO. 07557
2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
3-23-87 M

1. DECEASED NAME FIRST MIDDLE LAST
(TYPE OR PRINT) Bessie G. Leeson

3. SEX F 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR
5-12-1898

6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA 7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY - MD.

10. CITY OR TOWN OF DEATH BALTO. 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON D. LORD NURSING CNTR.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER 12b. KIND OF BUSINESS OR INDUSTRY HOME

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY 13c. CITY OR TOWN BALTO. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE 2609 ORLEANS ST. 21224

14. FATHER'S NAME FIRST MIDDLE LAST PERRY DEEM 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE POWELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 232-05-2105 17. INFORMANT ADDRESS Mrs. Margaret W. Leeson - 6009 Glenbrook Ave 21214

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) UGT Bleed.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) saw the body after death.)

22b. SIGNATURE DEGREE 22c. DATE SIGNED
Patricia J. Coon MD 3/24/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS
PATRICIA J. COON MD 4940 Eastern Ave, Balto, Md 21224

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 3-27-87 23c. NAME OF CEMETERY OR CREMATORY TOWER HILL CEM. 23d. LOCATION CITY OR TOWN COUNTY STATE
MONONGHA, W. VA.

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Barley Miller - 7527 Harford Rd. MAR 24 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return completed page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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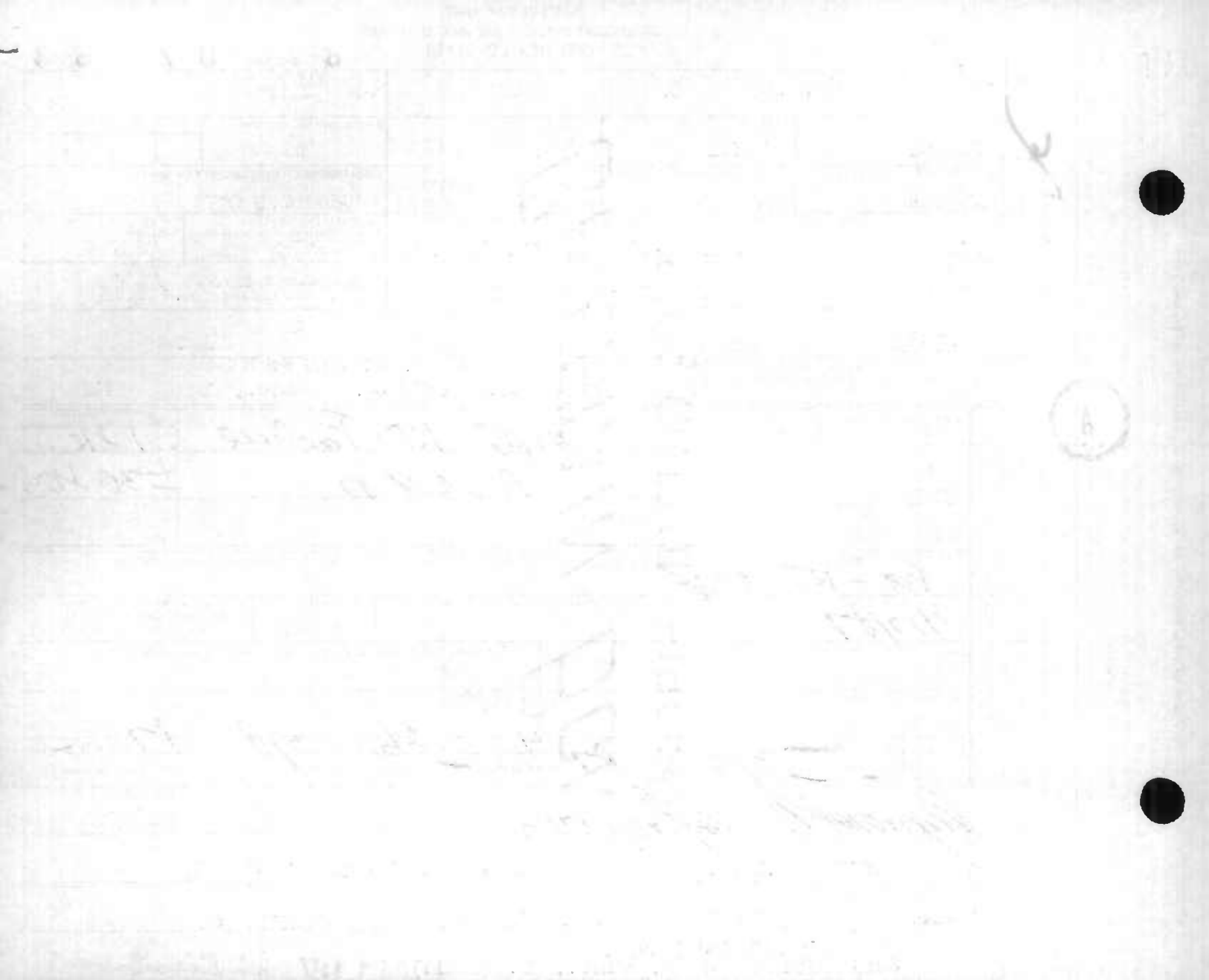


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and papers from this certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
HORTENSE C. LEHMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 8, 1987 | | 2b. HOUR
3 AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 7, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3117 BANCROFT RD. APT. A (21215) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3117 BANCROFT RD. (21215) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAMUEL COHEN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MOLLIE JANDORF | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-52-1754 | | 17. INFORMANT MR. BERNARD M. LEHMAN
ADDRESS
3701 FORDS LA. BALTO., MD 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congest NT. Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>30 hrs</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>30 hrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Pa - RT. NCP</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>1/17/87</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the deceased) attended the deceased from <u>3/7</u> 19 <u>87</u> , to <u>3/8</u> 19 <u>87</u> , that (I) <u>did</u> saw the deceased alive on <u>3/7</u> 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Raymond D. Caplan</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND D CAPLAN | | | | | 22e. ADDRESS
2435 W. BELVEDERE AVE (21215) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
3/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS.
6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Sanders-Rodney</u> | | |



849171

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Virginia L. Lloyd | | Lenzen | | | | | | 3-25-87 | | 6:50 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | Aug. 17 1917 | | 69 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Baltimore County | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Towson | | Stella Maris Hospice | | Homemaker | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | - BALTO. | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 123 Regester Ave., | | 21212 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Phillip Guy Lloyd | | Isabell Garter | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 212-07-5751 | | Robert L. Lenzen, | | 27 Dulaney Hills Ct., | | | | 21030 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) metastatic BREAST CANCER | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-24-87 to 3-25-87, that (I) (we) last saw the deceased alive on 3-25-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | |
| Carla S. Alexander, M.D. | | | | B-25-87 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Carla S. Alexander, M.D. | | Stella Maris Hospice | | 2300 Dulaney Valley Rd. - Towson, MD 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | 3/27/87 | | Druid Ridge Cem. | | Pikesville | | BALTO. | | MD. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| J. E. Lowell Lemmon, 10 W. Padonia Rd. | | MAR 27 1987 | | Julia Davidson-Randall | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

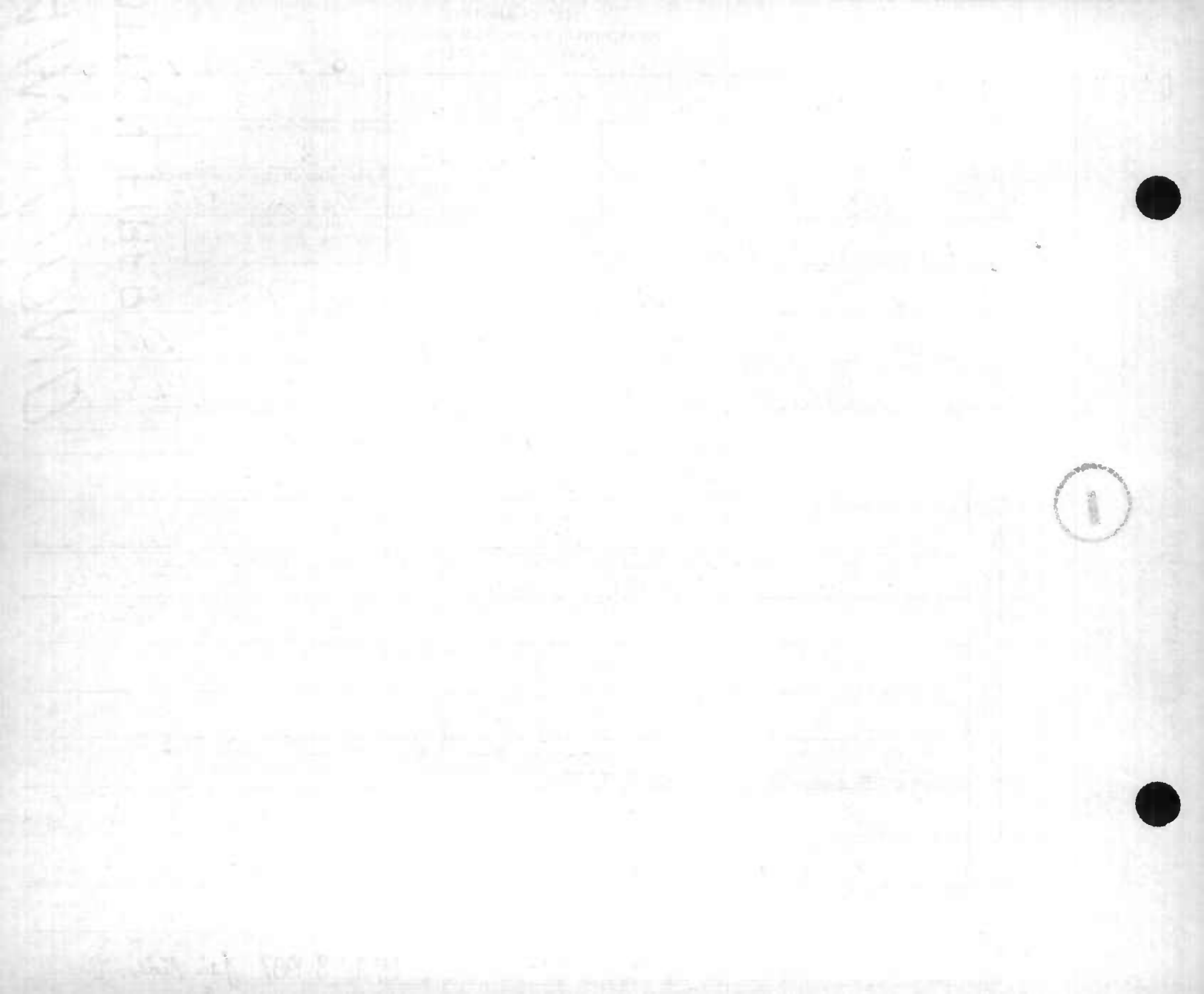
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|-----------|---|-------------------|---|---|--|-----------------------------------|---|-----------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2b. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| JOHN | | S. | LEONARD | 3 10 87 | | 7 | 57 | 30 | 00 | A |
| 3. SEX | M | 4. RACE | B | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| | | | | MONTH | DAY | YEAR | MONTHS | DAYS | HOURS | MIN. |
| | | | | 4 | 28 | 23 | 63 | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MD | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| | | North Charles Gen | | | | | MD. | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | ZIP CODE | |
| MD | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3302 Powhatan Ave | | 21216 | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | FIRST | MIDDLE | LAST | |
| Emory | | V. | Leonard | | Laura | | V. | Bark | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| Yes | | 218-14-2682 | | Annie Leonard | | 3302 Powhatan Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOMYOPATHY</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<u>RENAL FAILURE; SEPSIS; Hepatic Failure</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH,
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> 19 <u>87</u> to <u>3/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | |
| <u>Amba Hew Woreta</u> | | | | | | <u>3/10/87</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | |
| <u>AMBACHEN WORETA</u> | | <u>NORTH CHARLES HOSPITAL</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| Cremation | | 3/14/87 | | Westview Mem. Park | | Catonsville, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| <u>Wm C March F/H West</u> | | | | <u>4300 Wabash Ave.</u> | | <u>MAR 13 1987</u> <u>Julia Anderson-Randall</u> | | | | |

BP



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07561

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>Emma L. Leone</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>3/1/87</i> | | 2b. HOUR
<i>3.15 p M</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR
<i>2 14 11</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>75</i> | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>OHIO, USA</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>MD</i> | | | 13b. COUNTY
<i>Balto.</i> | 13c. CITY OR TOWN
<i>Dundalk</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Anthony DeSarro</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Maria Bottare</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>215 24 5955</i> | | 17. INFORMANT ADDRESS
<i>Patricia Ranocchia 10124 Davenetry Drive</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>pancytopenia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>multiple myeloma</i> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Diabetes</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I <input checked="" type="checkbox"/> this hospital) attended the deceased from <i>1/13</i> , 19 <i>87</i> , to <i>3/1</i> , 19 <i>87</i> , that (I <input checked="" type="checkbox"/> we) last saw the deceased alive on <i>3/1</i> , 19 <i>87</i> , and that in (my <input checked="" type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above. (I <input checked="" type="checkbox"/> we <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.) | | | | | |
| 22b. SIGNATURE
<i>Suzanne Holroyd MD</i> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>3/1/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>SUZANNE HOLROYD MD</i> | | 22e. ADDRESS
<i>Francis Scott Key Hospital, Baltimore MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>3/5/87</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Garden of Faith</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Rossville Balto. Maryland</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Connelly Funeral Home of Dundalk</i> | | ADDRESS
<i>21222</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 04 1987</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Richard R. Randa</i> | |

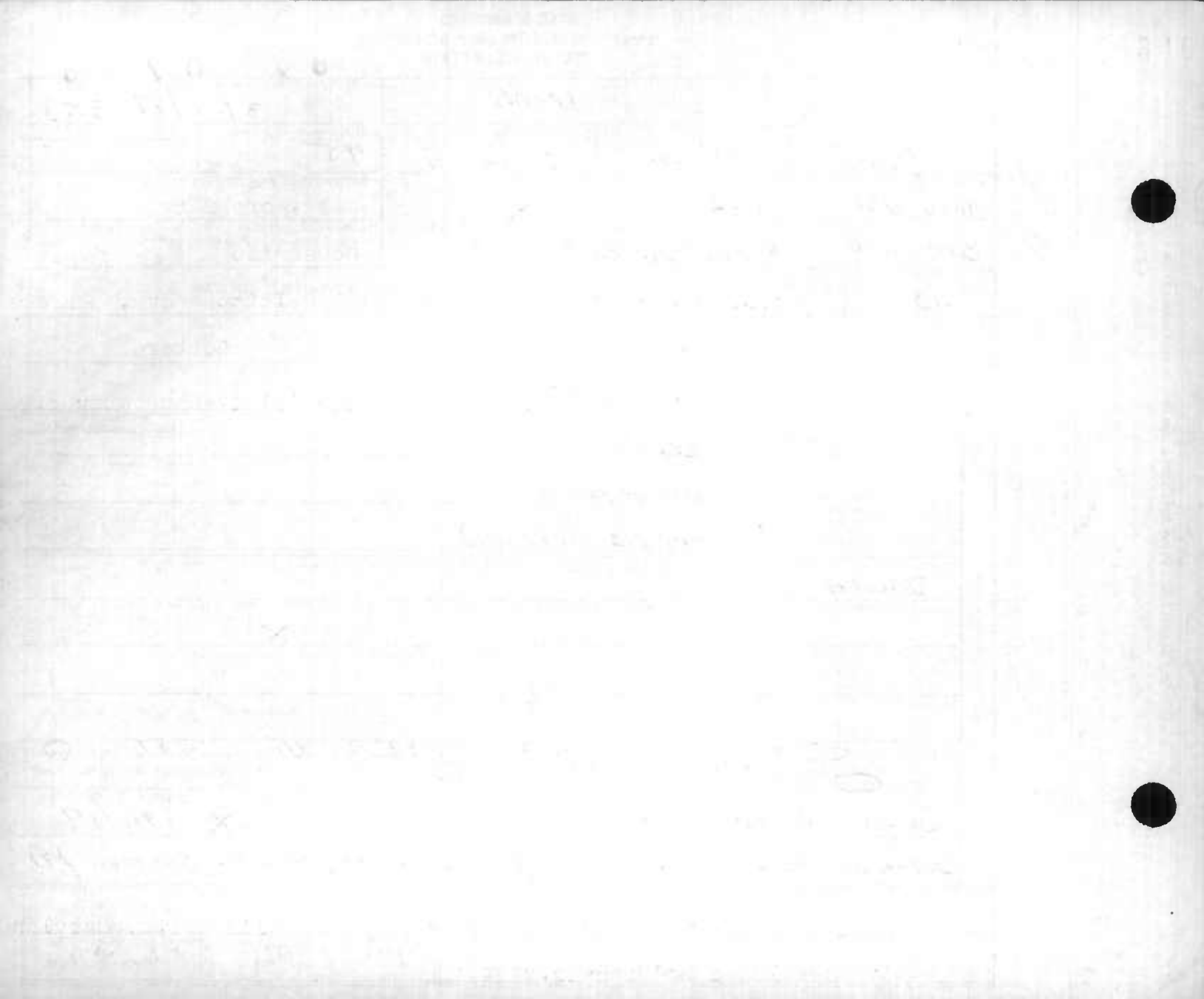
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the container with the carbon papers. Pages 1 and 2 should be buried with the body within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

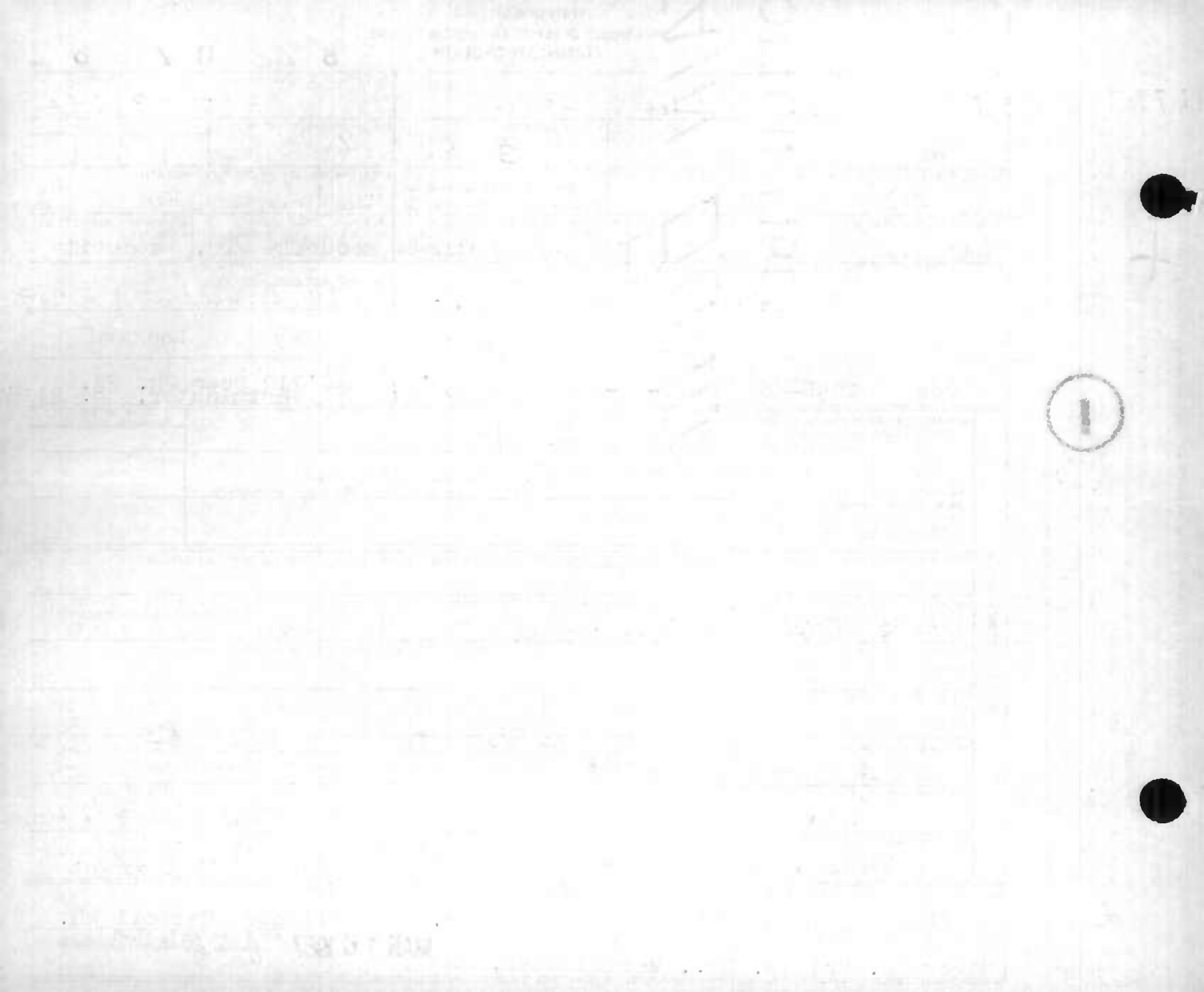
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 87 07562 | |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CLYDE Albert LEPPA | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 7 87 | |
| 3. SEX m | | | | 2b. HOUR
120 AM | |
| 4. RACE w | | 5. DATE OF BIRTH MONTH DAY YEAR
11 3 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | 12b. KIND OF BUSINESS OR INDUSTRY security | |
| 13a. STATE MD | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN Westminster | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Claude Leppo | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Stella May Lockard | | 17. INFORMANT A. Bitzel ADDRESS
Hospital Chart Westminister Rd. 21157 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. 1945-46 | | 17. INFORMANT A. Bitzel ADDRESS
Hospital Chart Westminister Rd. 21157 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION 12/18/86, 12/30/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pituitary Tumor | | 20a. AUTOPSY? YES NO | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12 19 86, to 3/7 19 87, that (I) (we) lost saw the deceased alive on 3/7 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Charles Cheng M.D. | | DEGREE M.D. ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN | | 22c. DATE SIGNED 3/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES CHENG M.D. | | 22e. ADDRESS Univ. of Maryland Hosp 225 Greene Balto MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY Deer Park Meth. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Smallwood Carroll MD. | | 23e. DATE OF DEATH 3/9/87 | | 23f. REGISTRAR'S SIGNATURE | |
| 24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminister, MD | | 25. REGISTRAR'S SIGNATURE | | | |

MAR 16 1987



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

1 - FOR
STATE
REGISTRAR

8 REG. NO. 07563

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR MIN.

WADELL

LESTER, Sr.

3 13 87 230 P.M.

3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

M

B

8 14 20

66 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH

Ua.

USA

BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

Baltimore

MASON F. LORD CHRONIC HOSPITAL

Construction

13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE

MD

Baltimore

3804 Penhurst Ave 21215

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

James

Lester

Allie

Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

No

234-32-7264

Russky Lester

3804 Penhurst Ave

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUDDEN CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, END-STAGE RENAL DISEASE, COPD.

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE 22c. DEGREE 22d. DATE SIGNED 3-13-87

22e. PHYSICIAN'S NAME (TYPE OR PRINT) 22f. ADDRESS

ROBERT B SCOTT

FSK Med Center

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE

Burial

3/19/87

Arbutus Mem. Pk.

Arbutus, Md.

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Wm C March F/H West

4300 Wabash Ave.

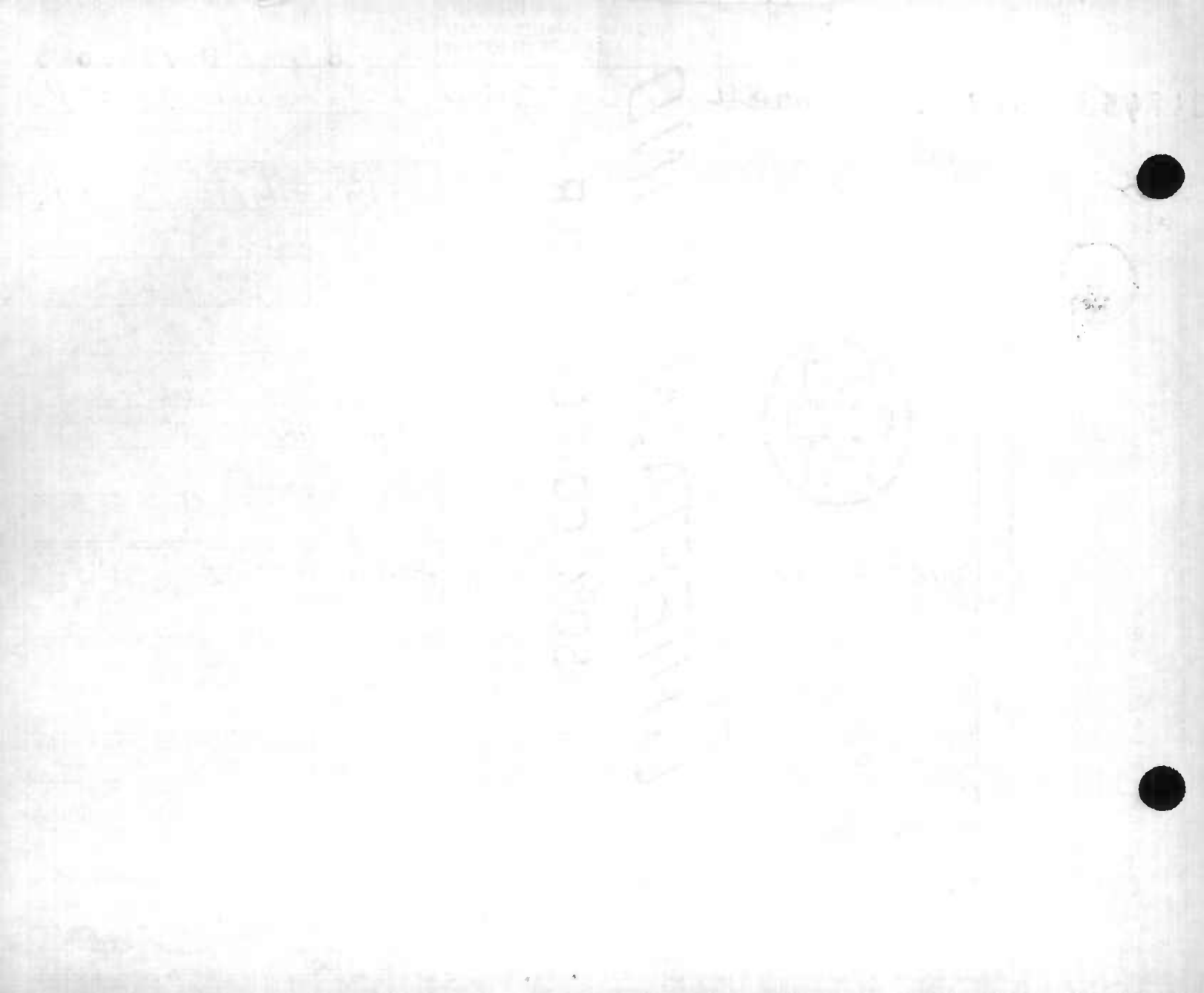
17 1987

[Signature]

0 47 453 MAR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death, page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

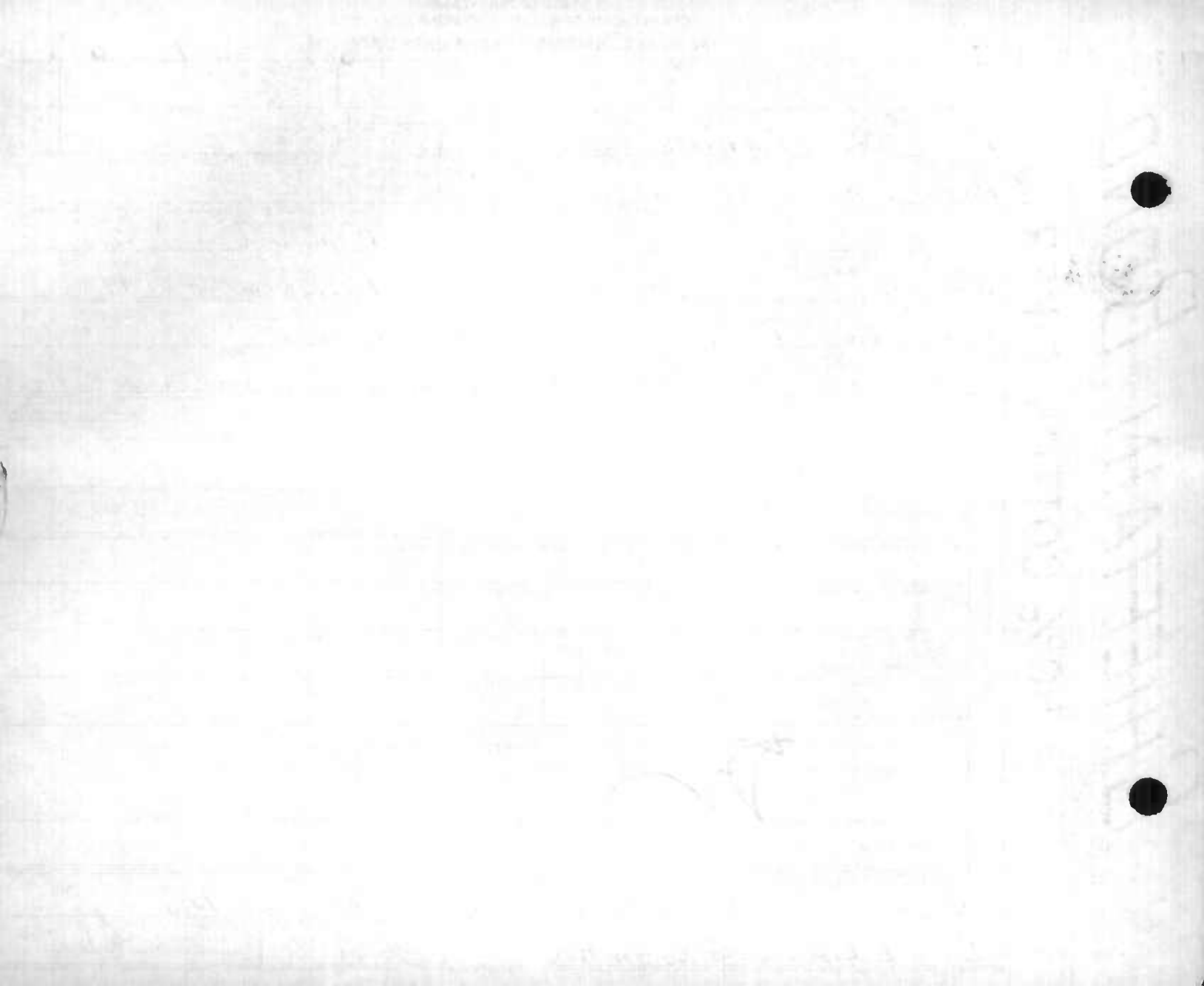
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (or completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical record must be available at the time of filing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 87 REG. NO. 07564 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARTHA - LEVY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3/27/87 | | | 2b. HOUR
3:35 PM | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
3 24 87 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
BALTO. CITY CT. | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
MORRIS COHEN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
FANNIE LEVIN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
216-03-6539 | | 17. INFORMANT ADDRESS
DAVID LEVY 5722 RANNY RD. BALTO., MD 21209 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA
DUE TO, OR AS A CONSEQUENCE OF (b) OVERWHELMING PNEUMONIA / UTI
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: D. MALLEUS. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27, 1987, to 3/27, 1987, that (I) (we) last saw the deceased alive on 3/27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
P. Talwar | | | 22c. DATE SIGNED
3/27/87 | | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAWKAJ TALWAR | | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL OF MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
MAR. 29, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
ANSHE EMUNAH | | 23d. LOCATION
BALTIMORE COUNTY MARYLAND | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP



049475 APR-68

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and, completely, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07566 | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) E. Inna Lewis | | | | | | 2a. DATE OF DEATH
MONTH 3 DAY 31 YEAR 87 | | | | 2b. HOUR
745 M | | | |
| 3. SEX
Female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH 8 DAY 7 YEAR 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MED. CENT. | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
4866 GREENCREST ROAD 21206 | |
| 14. FATHER'S NAME
FIRST ROBERT MIDDLE LAST NICHLAS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MATTIE MIDDLE CRUMP LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
 | | 17. INFORMANT
CHART | | | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 87 , to 3/31 , 19 87 , that (I) (we) last saw the deceased alive on 3/30 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Andrew Dobin | | | | | | DEGREE
 | | 22c. DATE SIGNED
3/31/87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Andrew Dobin | | | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
REMOVAL | | | | 23b. DATE
3-31-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN DINWITTIE COUNTY VIRGINIA STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME E.E. PHILLIPS ADDRESS 1721-27 N. MONROE ST. | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 3 1987 | | 25b. REGISTRAR'S SIGNATURE
Andrew Dobin | | | | | |

BP

4/9



048170 MAR 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07567

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Alfred C Linke SR. | | | 2a. DATE OF DEATH
MONTH 3 DAY 19 YEAR 87 | | | 2b. HOUR
6:37 AM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 9 DAY -29 YEAR -22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Warehouse Balto. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Business Form | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7611 Maple Road 21222 | | | |
| 14. FATHER'S NAME
FIRST Emil MIDDLE LAST Linke | | | | 15. MOTHER'S MAIDEN NAME
FIRST Louisa MIDDLE LAST Ranker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
214-12-2388 | | 17. INFORMANT
ADDRESS
Marie A. Linke 7611 Maple Road 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory
DUE TO, OR AS A CONSEQUENCE OF
(b) Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 3/16 , 19 87 , to 3/19 , 19 87 , that (I) (we) lost saw the deceased alive on 3/16 , 19 87 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
RW Wisner-Carlson MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/19/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RW Wisner-Carlson MD | | | | | | 22e. ADDRESS
Francis Scott Key Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
3-23-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY Maryland STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Duda-Ruck Funeral Home of Dundalk
ADDRESS 7922 Wise Ave. Dundalk, MD 21222 | | | | | | 25a. DATE REC'D BY REGISTRAR
MAR 23 1987 | | | 25b. REGISTRAR'S SIGNATURE
Julia Denden-Randee | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove certificates Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | 87 REG. NO. 07568 | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ALEXANDER LINTZ Jr | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR MARCH 23, 1987 | | | 2b. HOUR
1:35 P M | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR 2 14 31 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Building | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
241 S Broadway 21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alexander Lintz Sr | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hilda Mutzes | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218 26 5590 | | 17. INFORMANT Pasadena, Maryland 21122
DONNA COGLE 306 Sharon Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) SERVER LIVER DISEASE WITH PARTIAL HYPERTENSION | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Severe liver disease & partial hypertension. | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21/87 to 3/23/87 , that (I) (we) last saw the deceased alive on 3/23/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
V. SUDAN M.D. | | | | 22e. ADDRESS
100 N. Broadway, Balto MD 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
3/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY
Catonsville Balto MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Glen Burnie, Md 21061
Raymond C. Fink Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

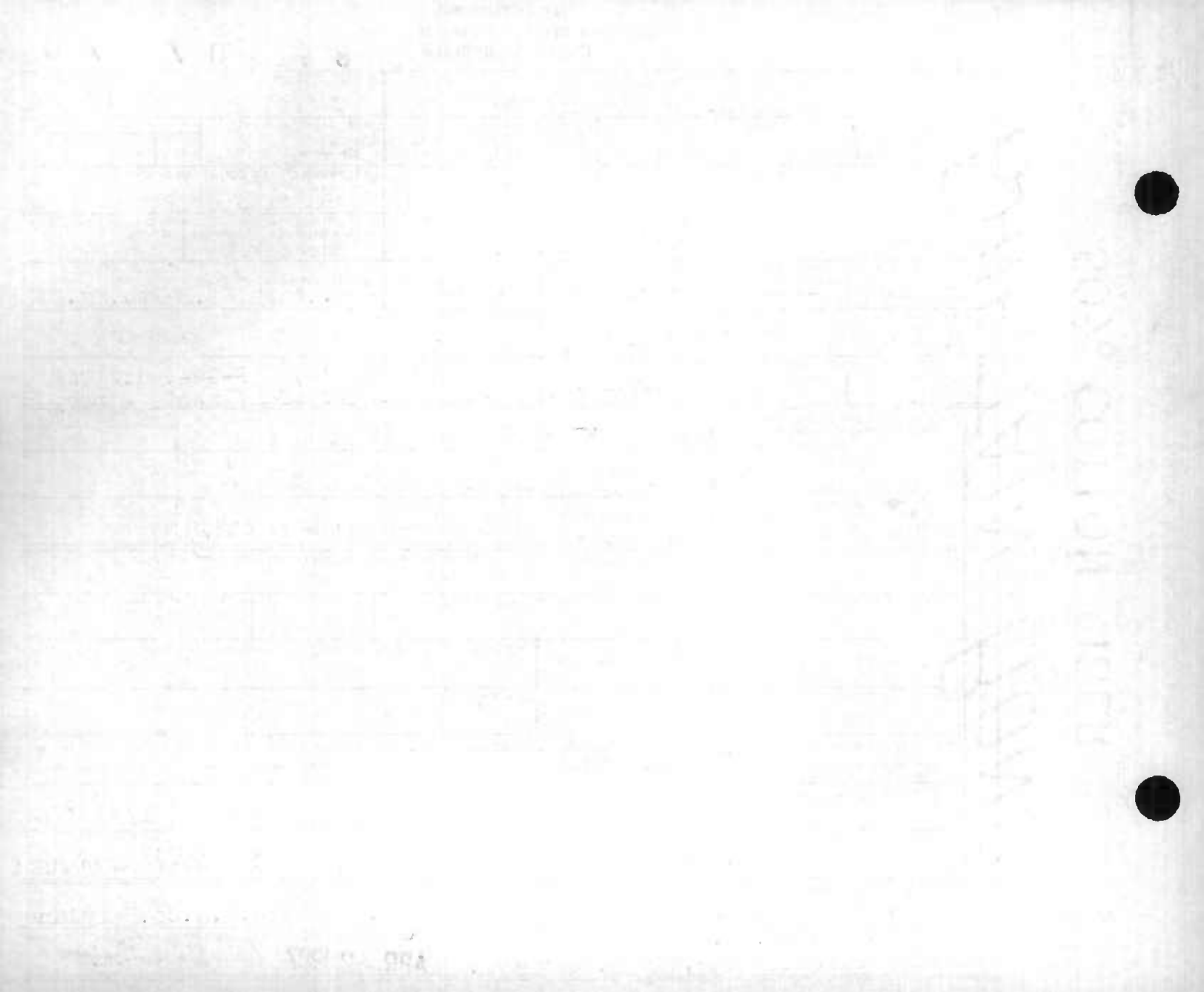
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07570

| | | | | | |
|---|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary E. Lotz | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 31 87 | | 2b. HOUR
8:50 PM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8 01 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SCHOE Balto.Md. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alfred G W. (Kens) | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E Nagel | | 16. STREET ADDRESS / ZIP CODE
9 E. Heath St. Balto. Md. 21230 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-22-1638 | | 17. INFORMANT
ADDRESS
Sykesville, Balto. Md. 21748
Carolyn E. Smith, 883 Fannie Dorsey Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic NonSmall cells of Lung
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive Heart Failure 2y to
DUE TO, OR AS A CONSEQUENCE OF
(c) Progression of NonSmall Cells of Lung | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 3/31/87 19 07 , to 3/31/87 19 07 , that (I) (we) lost
saw the deceased alive on 3/31/87 19 07 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE | | 22c. DATE SIGNED
3/31/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Maria E. Rodriguez MD | | 22e. ADDRESS
3001 South Hanover St Balto Md 21230 | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
4-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemt. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. A.A. Co. Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
McCully Funeral Home, 130 E. Fort Ave. | | | |
| 25a. DATE REC'D. BY REGISTRAR
APR - 2 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 07569
REG. NO. | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John Arthur Loftis, Jr. | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 16 87 | | | | 2b. HOUR
2125 M | |
| 3. SEX
male | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 21 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
COCA COLA | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2510 W. PATAPSCO AVE. APID 21230 | |
| 14. FATHER'S NAME
JOHN | | MIDDLE
LOFTIS | | 15. MOTHER'S MAIDEN NAME
ROANN | | MIDDLE
MCCALISTER | | LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
244226036 | | 17. INFORMANT (28306)
LINWOOD FISHER 2223 PROGRESS ST. | | ADDRESS
FAYETTEVILLE, NC. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hemoptysis 2° to Aspergilloma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Acute Renal Failure</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<u>Renal Insufficiency, Hypertension, Severe Chronic Obstructive Pulmonary Disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/12</u> , 19 <u>87</u> , to <u>3/16</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Brad Norman</u> | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Brad Norman, M.D. | | | | 22e. ADDRESS
900 S. CATON AVENUE BALTO. MD. 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY
CHURCH CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FAYETTEVILLE N.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME | | | | ADDRESS
1101 E. NORTH AVE. | | 25a. DATE REC'D. BY REG. CLERK
MAR 19 1987 | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07571

| | | | | |
|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HERBERT G. LOUD | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH - 15 - 87 | | 2b. HOUR
3:40 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 27, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Joseph Richey House | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Rep. | 12b. KIND OF BUSINESS OR INDUSTRY
Pharmacology |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | 13b. CITY OR TOWN
Balto. | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13. STREET ADDRESS & ZIP CODE
3 Southerly Ct., 21204 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herbert G. Loud | | 15. MOTHER'S MAIDEN NAME
Katharine J. Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
Yes WW II | 16b. SOCIAL SECURITY NO.
213 10 5482 | 17. INFORMANT
ADDRESS
Mrs. Margaret Loud, Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Anoxia + Resp. Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic Carcinoma, Brain</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of Lung</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 month</u>
<u>2 wks.</u>
<u>2 yrs.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3-10</u> , 19 <u>87</u> , to <u>3/15</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>3-15</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
<u>Robert C. Irwin M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3-15-87</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Robert C. Irwin M.D.</u> | | 22e. ADDRESS
<u>828 N. Eutaw St. Balto Md. 21201</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/18/87 | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

100-1070000-4211

1. What is the purpose of the study?
 2. What are the research objectives?
 3. What is the scope of the study?
 4. What are the limitations of the study?
 5. What are the key findings?
 6. What are the conclusions?
 7. What are the recommendations?
 8. What are the future research directions?
 9. What are the references?
 10. What are the appendices?

1. Work with the team to complete the project on time and within the budget.
 2. The team will be responsible for the completion of the project on time and within the budget.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this file and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or unusual cause of death, the examiner must be notified by the physician.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST: <u>Willie</u> MIDDLE: LAST: <u>Love</u> | | | | | 2a. DATE OF DEATH
MONTH: <u>3</u> DAY: <u>19</u> YEAR: <u>87</u> | | | 2b. HOUR
<u>5:48</u> P.M. | |
| 3. SEX
<u>male</u> | | 4. RACE
<u>Black</u> | | 5. DATE OF BIRTH
MONTH: <u>8</u> DAY: <u>25</u> YEAR: <u>19</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>67</u> YRS. | | IF UNDER 1 YEAR
MONTHS: DAYS: HOURS: MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>N/A</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>unknown</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>CITY</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>South Baltimore General Hosp</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>unknown</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | |
| 13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>-</u> | | 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>1900 Dukeland St. 21216</u> | |
| 14. FATHER'S NAME
FIRST: <u>Jack</u> MIDDLE: LAST: <u>Love</u> | | 15. MOTHER'S MAIDEN NAME
FIRST: <u>Mannie</u> MIDDLE: LAST: <u>Kenrick</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>unknown</u> | | 16b. SOCIAL SECURITY NO.
<u>7180786520</u> | | 17. INFORMANT
ADDRESS: <u>Peggie Love 3525 Gelsted Dr. #29</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>pneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>non small cell lung CA</u>
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>-</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert Steadman MD</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3/19/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Robert STEADMAN</u> | | | | 22e. ADDRESS
<u>3001 S. Hanover ST</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>3/24/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Md. National Cem.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Laurel Md.</u> | | | |
| 24. FUNERAL DIRECTOR
NAME: <u>W.C. March F/H 4300 Wabash Ave. West</u> ADDRESS: <u>-</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 23 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | | | |

25

1

CO. 1001

049330 APR 1987

FOR STATE REGISTRAR UNKNOWN#87-34

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07573

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|-------------------------|--|------------------|--|--------------------------|--|-------|--|----------|--|------|--|----------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| Alfred | | | | | | Lucio | | 3-17 | | 19 | | 87 | | | | M | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | | |
| Male | | White | | 11 13 42 | | 44 YRS. | | MONTHS | | DAYS | | HOURS | | MIN | | 3-18- | | 19 | | 87 | | 9:35 a M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Massachusetts | | U.S. | | | | Baltimore City | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| Baltimore | | 929 E. Baltimore St (vacant bldg) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | |
| Md. | | | | Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 709 E. Eager St. 21202 | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | | | |
| No | | 016-32-4334 | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Blunt injuries to head | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3-17 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | SUBJECT BEATEN | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Vacant building | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 929 E. Baltimore St (vacant Bldg) Balto., MD | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) Assistant | | DATE SIGNED 3-18-87 | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. | | ADDRESS 111 Penn St., Balto, MD 21201 | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 3-31-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME State Anatomy Board | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR APR 03 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |

07/84 BP DHMH - 17 (VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

4/9



46204 MAR-87

FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07574

| | | | | | | |
|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Earl Wallace LYLES -el | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 3, 1987 | | 2b. HOUR
6:35A M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 20 53 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
33 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
506 Laurens Street 21217 | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wallace Lyles | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillie Palmer | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-56-7962 | | 17. INFORMANT ADDRESS
Lillie Lyles 1219 Druid Hill Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. Ventricular arrhythmia
IMMEDIATE CAUSE (a)
DUE TO OR AS A CONSEQUENCE OF
(b) dilated cardiomyopathy
DUE TO OR AS A CONSEQUENCE OF
(c) Alcoholism | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
3 years
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
Alcoholic Liver disease; Positive for hepatitis antigen; Boarderline positive HTLV3 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 28, 1987 , to March 3, 1987 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on March 3, 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (If (we) did not view the body after death, so state.) | | | | | | |
| 22a. SIGNATURE
Sera LaRondelle | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
3/5/87 |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
LA RONDELLE | | 22e. ADDRESS
c/o Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/7/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansdown Md. |
| 24. FUNERAL DIRECTOR
NAME
Chatman-Harris FH | | ADDRESS
1701 McCulloh St. | | 25a. DATE REC'D. BY REGISTRAR
MAR 05 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Henderson-Randall | | | | | | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully the pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the Department of Health and Mental Hygiene, Baltimore, Maryland, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 87 REG. NO. 07575 | |
| 1 DECEASED NAME (TYPE OR PRINT)
Virginia P. MacGill | | 2a. DATE OF DEATH MONTH DAY YEAR
03 07 87 | |
| 3. SEX
Female | 4 RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
August 25, 1916 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 9b. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | 10. CITY OR TOWN OF DEATH
Baltimore | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Maryland | 13b. CITY OR TOWN
Baltimore | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
327 Homeland Southway 21212 |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Walter A. Patrick, Jr. | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Millicent G. Leech | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
215 22 1746 | 17. INFORMANT ADDRESS
John C. MacGill Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ammonia Encephalopathy</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Liver Cirrhosis</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
7 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>87</u> , to <u>3/7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Stacy O. Ross</u> | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
3/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stacy O. Ross, MD | 22e. ADDRESS
Union Memorial Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | 23b. DATE
03/08/87 | 23c. NAME OF CEMETERY OR CREMATORY
Eline Crematory | 23d. LOCATION CITY OR TOWN COUNTY STATE
Hampstead, Carroll Co., MD |
| 24. FUNERAL DIRECTOR NAME
Burgee-Henss Funeral Home, Baltimore, MD 21211 | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07576 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
ESTELLE CATHERINE MADDOX | | | | 2b. HOUR
4:00 P | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 17, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Sparrows Pt., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital, Inc. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frank Janowitz | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Kwedar | | 13e. STREET ADDRESS / ZIP CODE
6609 Pine Ave. 21222 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219.03.3393 | | 17. INFORMANT ADDRESS
Jeffrey Shagena 3473 Liberty Pkwy. Dundalk Md. 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE ORGAN SYSTEM FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) PERFORATED PYLORIC ULCER WITH OBSTRUCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
PERFORATED PYLORIC | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 21, 1987, to MARCH 20, 1987, that (I) (we) lost the deceased alive on MARCH 20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Y.K. SHETTY | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/20/87. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Y.K. SHETTY | | 22e. ADDRESS
Church Hosp CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/23/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Mary | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Dundalk Balto. Md. | |
| 24. FUNERAL DIRECTOR
Walter Brooks Bradley Inc., Dundalk Md. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

NOT FOR RELEASE

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

DATE 11/18/01 BY SP-6
[Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified at once.

DHMH - 16 60M 7/84
(VRA 15. 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Edna E. Madison | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 5, 1987 | | | 2b. HOUR
1:00A. M | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 03, 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Haven Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | 13b. COUNTY
Balto. City | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3806 Hickory Avenue 21211 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Johnson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Southerland | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215 18 6766 | | 17 INFORMANT
ADDRESS
Robert Byrley 3806 Hickory Avenue 21211 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>C.O.P.D.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Senile dementia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
(WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-4</u> <u>10</u> <u>1986</u> , to <u>3-4</u> <u>1987</u> , that (I) (we) last saw the deceased alive on <u>1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>view the body after death.</u> | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
<u>MD.</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Dorcas H. O'Brien-Smith MD</u> | | | | 22e. ADDRESS
<u>303 N. Rollins Rd</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/7/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn, Balto. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Burgee-Henss Funeral Home | | | | ADDRESS
3631 Falls Rd. | | 25a. DATE RECEIVED BY REGISTRAR
MAR 09 1987 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

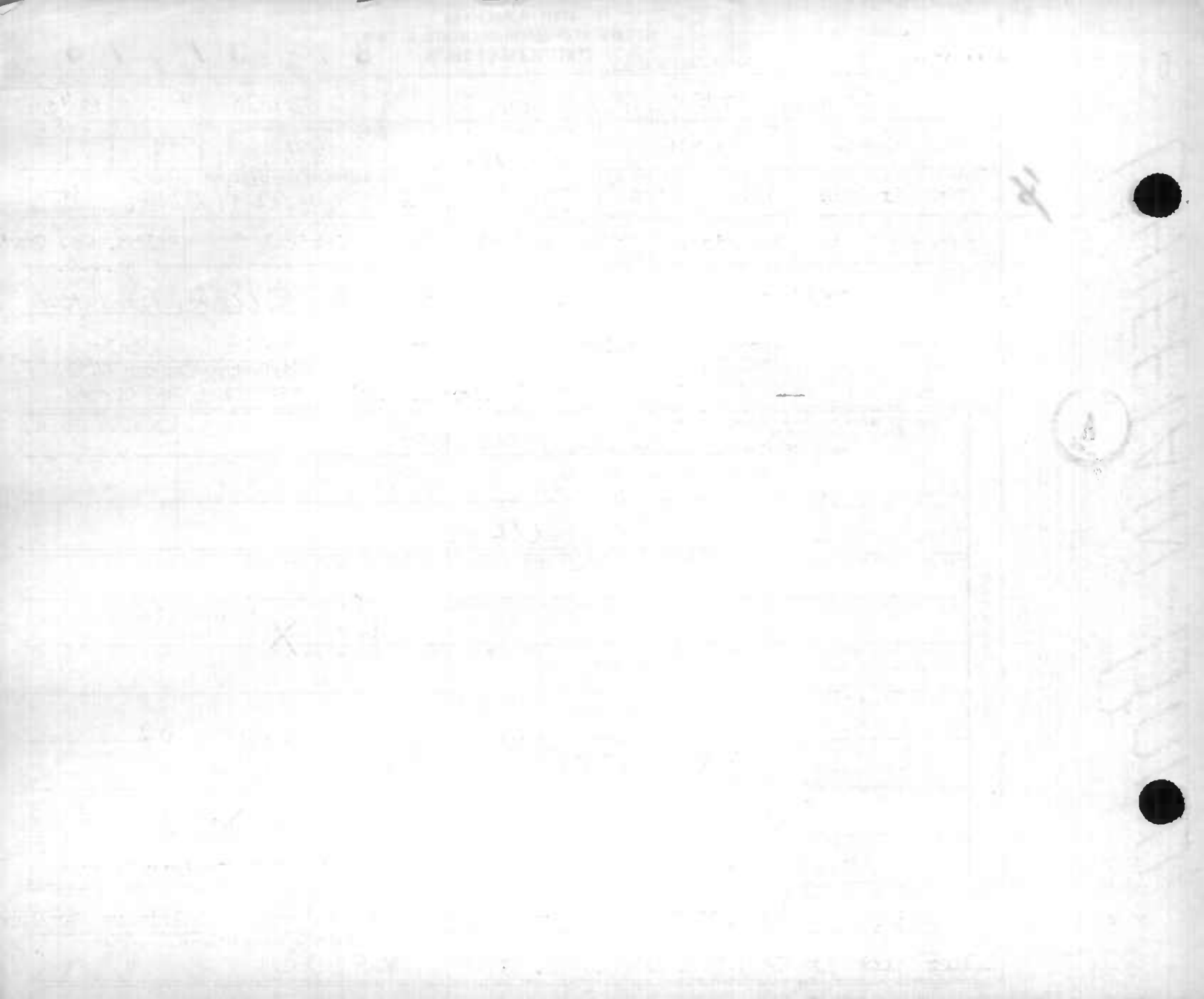


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and 12 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

IF THE MEDICAL EXAMINER IS NOTIFIED PRIOR TO BURIAL, THE MEDICAL EXAMINER'S SIGNATURE MUST BE OBTAINED PRIOR TO THE BURIAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) PEARL Bartley MADISON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 03/08/87 | | 2b. HOUR 6:45 M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 06 12 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Govt | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. CITY OR TOWN Baltimore 13c. CITY OR TOWN Dundalk | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 6912 Sollers Point Rd 21222 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Burton Bartley | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Cecelia Marks | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 215-42-7122 | | 17. INFORMANT ADDRESS Wichita, Kansas 67214 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) s/p MI
DUE TO, OR AS A CONSEQUENCE OF (c) infection
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/3 19 87 to 3/8 19 87 , that (I) (we) last saw the deceased alive on 3/8 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE JANECUR DEGREE | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 3/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JANECUR M.D. | | | | | 22e. ADDRESS FSK HOSP. 4940 Eastern Avenue | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE March 11, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Balto., Md. 21222 ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07579
REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LORENZO MALARY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03/30/1987 | | 2b. HOUR
13:25M |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
10/31/1904 | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. CITY OR TOWN
Catonsville | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tom Malary | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-09-6848 | | 17. INFORMANT ADDRESS
Marjorie Malary 329 HollyManor | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prostatic Carcinoma, metastatic
DUE TO, OR AS A CONSEQUENCE OF
(b) DIC
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Ronald J. Urban | | DEGREE
MD | | 22c. DATE SIGNED
3/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Twilight Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Weldon N.C. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
APR - 2 1987 | | | |
| 24. FUNERAL DIRECTOR
William C. March F/H 1701 E. North Ave. | | | | | |

BP

2011 11/10/10

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11/10/10

4/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07580

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|---|--|-----------------------------------|--|--|---|-----------------------------------|------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARTA MALIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 2 87 | | 2b. HOUR
12 ⁵⁸ P.M. | | | | | | |
| 3. SEX
F | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 2 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 72 HRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |

| | | | | | | | | | | | |
|--|--|--|--|--|--------------------------------|---|---|--|---|--|--|
| 13a. STATE
MD | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3508 Copley Rd. 21215 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
AGOSTINO CINQUEGRANA | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MICHELINA DE VITA CINQUEGRANA | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
NO | | | | | |
| 16b. SOCIAL SECURITY NO.
220-56-3038 | | | 17. INFORMANT
ADDRESS
PHILIP L. MALIN - 25 EASTLAND DR. LANCASTER, PA. 17602 | | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Right lung atelectasis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Metastatic breast cancer

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2/87, 1987, to 3/2/87, 1987, that (I) (we) lost
saw the deceased alive on 3/2/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Elam | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELAM | | 22e. ADDRESS
SINAI HOSPITAL | | | | | |

| | | | | | | | |
|---|--|---------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. MARY CATHOLIC CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LANCASTER LANC PA. | |
| 24. FUNERAL DIRECTOR
NAME
Vince Johnson - 8521 Loch Raven Blvd. | | | | 25. DATE REC'D. BY REGISTRAR
MAR 24 1987 | | | |

THE UNIVERSITY OF CHICAGO
LIBRARY

1862

LIBRARY

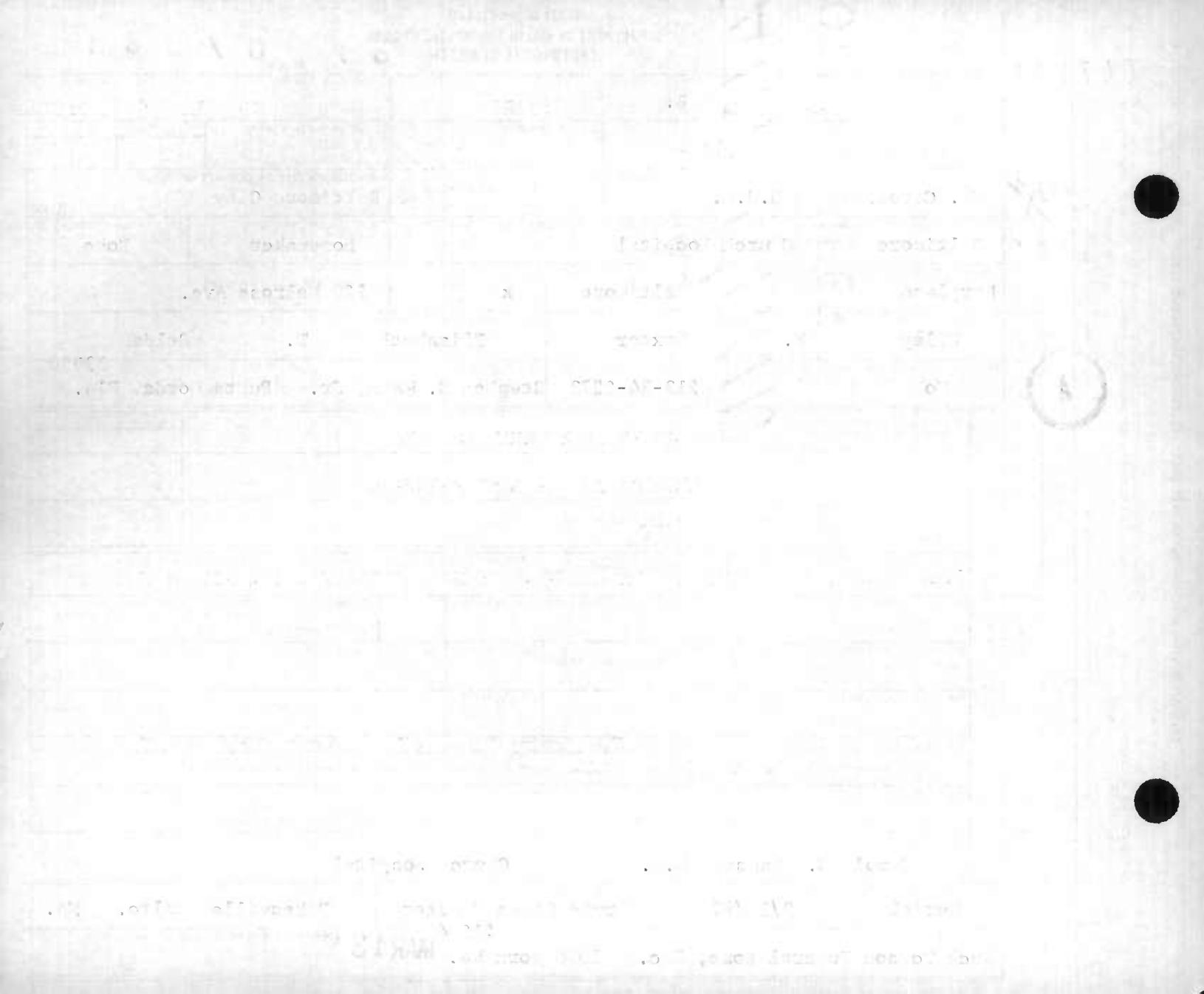
1862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|-------------------|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR
047281 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ROSALIE B. MANN | | | | | | 03 12 87 | | 12:30am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| FEMALE | | White | | 3 11 88 | | 99 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MD. | | | |
| No. Carolina | | U.S.A. | | | | Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Church Hospital | | | | Homemaker | | Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | | | Baltimore | | YES | | 120 Melrose Ave. 21228 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Wiley M. Baxter | | | | Elizabeth T. Selden | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NEVER UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | 33950 | | | |
| | | 213-34-2273 | | Stephen S. Mann, Jr. | | Punta Gorda, Fla. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PNEUMONIA, POSSIBLE DEHYDRATION, RENAL FAILURE, POSSIBLE UTI | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| NONE | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 25, 19 87, to March 12, 19 87, that (I) (we) lost saw the deceased alive on March 12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| Carol S. Ramsey | | | | D.O. | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Carol S. Ramsey M.D. | | | | Church Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 3/16/87 | | Druid Ridge Cemetery | | Pikesville Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REG. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Ruck Towson Funeral Home, Inc. | | | | 1050 York Rd. | | MAR 13 1987 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 87 | | REG. NO. 07582 | | | | | |
| 2. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ILENE L. MANOLAROS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 31, 1987 | | 2b. HOUR
7:14A M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Feb. 14 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
2101 Brookmead Ct. 21136 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Hood | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Myrtle Mathias | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-07-1189 | | 17. INFORMANT
Nicholas J. Manolaros | | ADDRESS
Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiovascular arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>pulmonary embolism</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>mesodermal uterine cancer</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>20 min</i>
<i>12 hrs</i>
<i>8 months</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>post-reveal obstruction and small bowel obstruction</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/18</i> , 19 <i>87</i> , to <i>3/31</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>3/31</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Matthew R. Work</i> | | | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>3/31/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MATTHEW R. WORK</i> | | | | 22e. ADDRESS
<i>601 N Wolfe St Baltimore Md 21205</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-3-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Elaine Funeral Home Reisterstown, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 3 1987</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Anderson-Randall</i> | | | |

APR 3 1957

4/9

BP

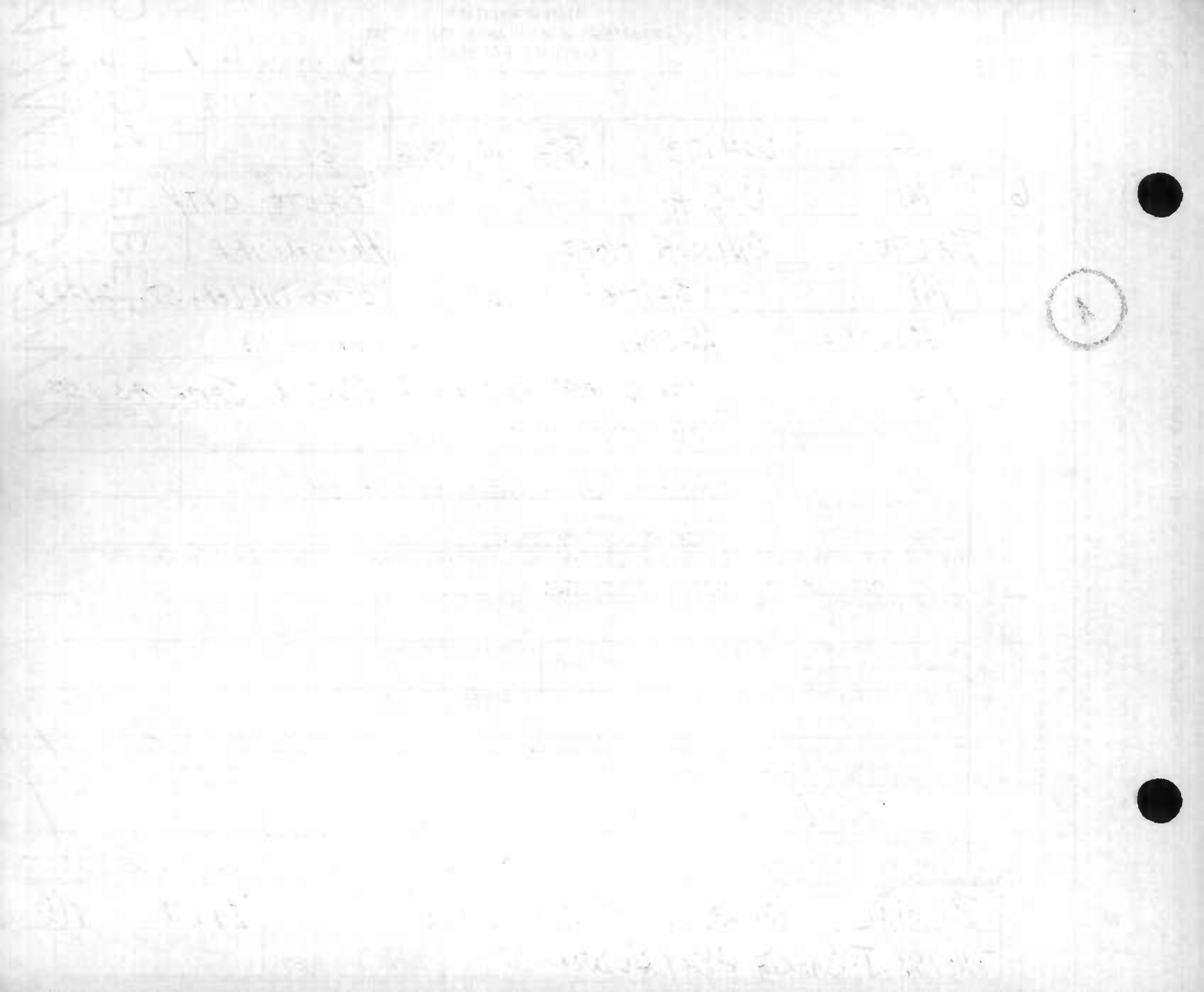
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07583 | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
DORIS B MANTIK | | | | MARCH 22, 1987 | | | | 11:40 AM | | | | | |
| 3. SEX
F | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
FEB. 14, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MD. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2700 DILLON ST. 21224 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
GARDNER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
230-12-4998 | | 17. INFORMANT ADDRESS
ANDREW H. MANTIK SAME AS 13e | | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: CARDIOPULMONARY FAILURE
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF
(b) CARDIAC MYOCARDIAL INFARCTION
(c) PULMONARY FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
CONGESTIVE HEART FAILURE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 9, 1987, to MARCH 22, 1987, that (I) (we) last saw the deceased alive on MARCH 22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Ramesh Kabaria | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAMESH KABARIA | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTO., MD. X88821231 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(BY TYPE)
BURIAL | | 23b. DATE
3-25-87 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. STANISLAUS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
THOMAS J. SHAKO 2829 HUDSON ST. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |



047241

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1584

| | | | | | | | | | | | | | | | | | | | |
|---|---------|------------------|---|---|------------------|--|--|---|---|--|--|---|--|--|--|---|--|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | HOUR | | | | | | | |
| Esther | | | Marsh | | | XX 3-2 | | | 19 87 | | | M | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | HOUR | | | | | | | |
| F | Black | 12 12 20 | 66 YRS. | MONTHS | DAYS | 3-3 | | | 19 87 | | | 12:35 M | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | |
| N. C. | | | U.S.A. | | | | | | Baltimore City, MD | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | | 1600 W. Mt. Royal Ave., Apt. 1305 | | | | | | Housewife | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | | | | | | | | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1600 Mt. Royal Ave. Apt. 1305 | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Unknown | | | | | | Unknown | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | | | | 212-20-6480 | | | | | | Moszie Marsh Jr. 2516 Linden Ave. 21217 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Disease | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| Diabetes Mellitus | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | Dennis F. Smyth, M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED 3-3-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | Dennis F. Smyth, M.D. | | | | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | | | 3-9-87 | | | | Mt Auburn | | | | Baltimore, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| William c. Brown 1206-08 W. North Ave. | | | | | | | | MAR 13 1987 | | | | [Signature] | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PLESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

1234

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

+

WATER
POISONING



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|----------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> <div>049439 APR 1987</div> <div>REG. NO. 8707585</div> </div> | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Harlee Marshall | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 31 1987 | | 2b. HOUR
M | | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 1 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2501 Violet Ave. Apt. #609-N | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2501 Violet Ave. 21215 | |
| 14. FATHER'S NAME
Rafe MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
Annie P. FIRST MIDDLE LAST | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-03-9813 | | 17. INFORMANT
ADDRESS
Ruth Marshall 2501 Violet Ave. Balto. MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 86 , to March 87 , that (I) (we) last saw the deceased alive on Feb 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Phyllis K. Smith | | | | DEGREE
P. K. Smith | | | | 22c. DATE SIGNED
4/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Phyllis K. Smith | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Bailey Funeral Home 1348 N. Calhoun St. 21217 | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 2 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rudner | |

4/9

100% COTTON FIBER

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove rubber stamps. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, a medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DOROTHY MAE MARTIN | | 2a. DATE OF DEATH 3-14-87 | | 2b. HOUR 12:30 AM | | | | | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH 07-27-14 | | | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY - | | 13a. STATE MD. | | 13b. COUNTY - | | | | | |
| 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5927 GREENHILL AVE. 21206 | | | | | |
| 14. FATHER'S NAME
FIRST HARRY MIDDLE IRVING LAST ROGERS | | 15. MOTHER'S MAIDEN NAME
FIRST RHODA MIDDLE MAE LAST DEARHOLT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-01-3540 | | 17. INFORMANT ADDRESS LYNN R. SCHULTZ (DGHTR) SAME ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) - | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DAYS
YEARS | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) - | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from FEB 25 19 87 , to MARCH 14 19 87 , that (I) (we) lost saw the deceased alive on MARCH 14 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jonathan A. Lewis | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3/14/87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan A. Lewis | | 22e. ADDRESS MERCY HOSPITAL 301 ST PAUL PL BALTIMORE MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 3/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK | | | | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE BALTO. MD. | | 24. FUNERAL DIRECTOR SCHIMONEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR MAR 17 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

BP

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with the attending physician. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07581

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
NARCISSUS G. MARTIN, Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 14, 1987 | | 2b. HOUR P
11:22 M |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
7-31-1916 | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
INDIANA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SHIP FITTER | 12b. KIND OF BUSINESS OR INDUSTRY
SHIP YARD | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NARCISSUS G. MARTIN, Sr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MATTIE MOTLEY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
248-09-6965 | 17. INFORMANT ADDRESS
Mrs. Barbara C. Francis - 22c. Prigat Ave.
Clifton, N.J. 07011 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Generalized Seizure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 min.
25 min. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Recent myocardial infarction, cerebrovascular accident</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>87</u> , to <u>3/14</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3/14</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Steven Jasti</u> | | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/14/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Steven B. Laster MD</u> | | | 22e. ADDRESS
<u>600 N. Wolfe St. Balt. MD 21205</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-18-87 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. CARMEL Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD |
| 24. FUNERAL DIRECTOR
NAME <u>Joseph Jasti</u> ADDRESS <u>2334 Jefferson St</u> | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Richard J. Hendricks</u> |

4770

0 180 59 12

RECEIVED
FEBRUARY 21 1964

0 780 2d 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place entire certificate in envelope, seal, and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07588

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) CLIFFORD LEO MASON | | | 2a. DATE OF DEATH MONTH DAY YEAR
03 21 87 | | 2b. HOUR
526 M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
11 18 09 | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Agnes | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machine Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Glass |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1934 Grinnalds Ave. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John B. Mason, Sr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Tivvis | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES Ww II | | 16b. SOCIAL SECURITY NO.
215-70-6588 | 17. INFORMANT ADDRESS
Niles R. Mason 31 Anderson ridge Rd. 21228 | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Hemorrhagic Shock, Exsanguination
DUE TO, OR AS A CONSEQUENCE OF
(b) Supracardiac Ruptured Aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hours |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION
3/21/87 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ruptured Aneurysm | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21 , 19 87 , to 3/21 , 19 87 , that (I) (we) lost saw the deceased alive on 3/21 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Pamela A. Lipsett MD | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
3/21/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Pamela A. Lipsett | | 22e. ADDRESS
St Agnes Hospital | |



| | | | |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
3/25/87 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Randall |

the



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07589

| | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES R. Mason, Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 21 87 | | | 2b. HOUR
5⁵⁵ PM | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 23 47 | | 6. AGE (IN YEARS LAST BIRTHDAY)
39 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3460 Park Heights Ave. #15 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Wiggins | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
214-445326 | | 17. INFORMANT
ADDRESS
Enez & Charles Mason | | | | 17. INFORMANT
NAME
SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac-pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Esophageal Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) CHF & Pulmonary edema.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 03/21 , 19 87 , to 03/21 , 19 87 , that (I) (we) lost
saw the deceased alive on 03/21 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thirteen L. Chioppewilliams | | | | | 22e. ADDRESS
Liberty medical center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H West 4300 Wabash Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | | | 25b. REGISTRAR'S SIGNATURE
 | | |



REG. NO.

MEDICAL CERTIFICATION

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

1

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

048071

MAR 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87

REG. NO. 07591

1- FOR
STATE
REGISTRAR

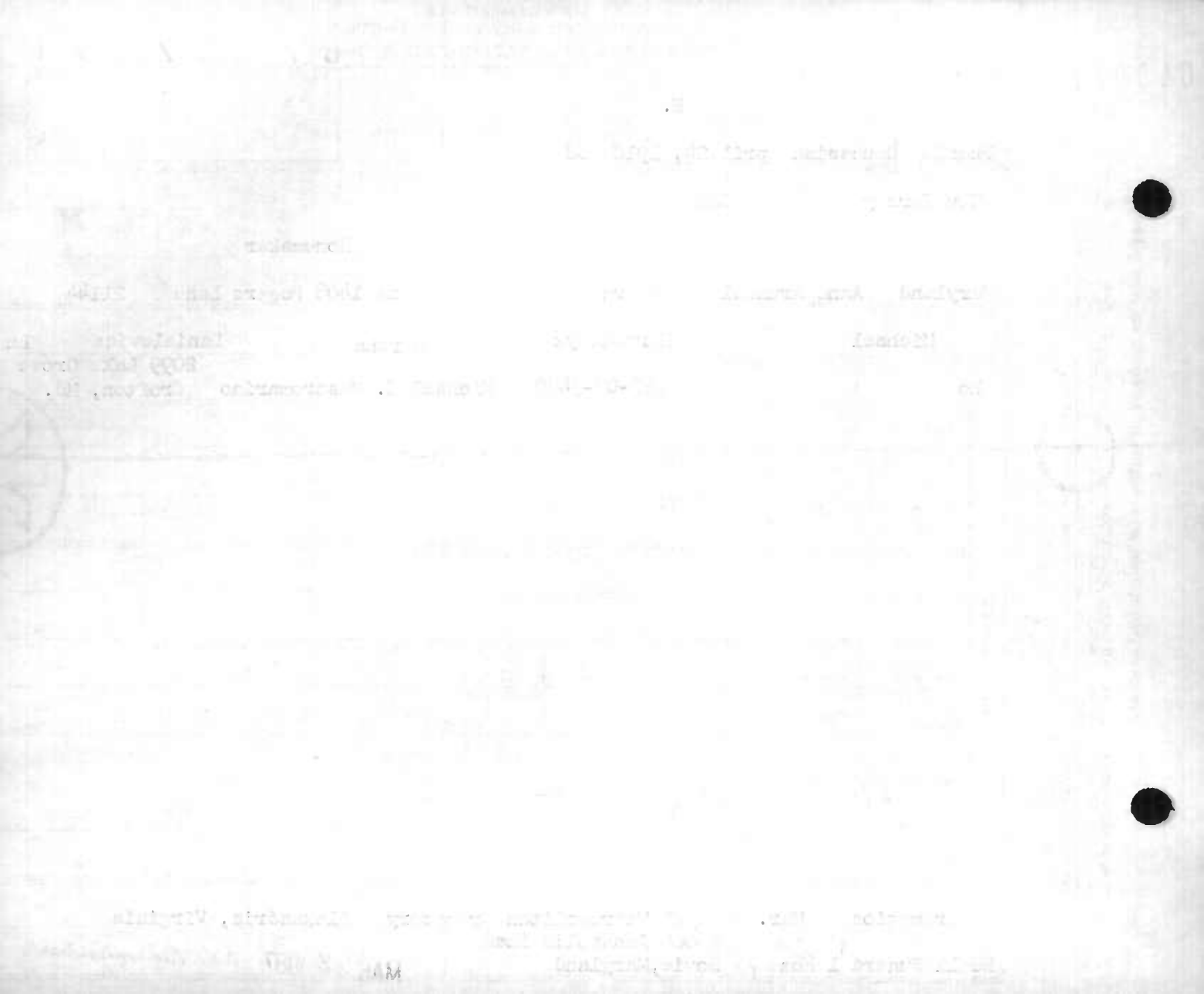
| | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|-----------------------------------|--|--|--|--------------|--|--------------------------------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
ESTI- MATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Patricia H. Mastromarino | | | | | | | | X | | 3-17 | | 19 | | 87 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS | | IF UNDER 24 HRS.
HOURS | | MIN | | 2c. DATE
PRONOUNCED
DEAD | | 2d. HOUR | |
| Female | | Caucasian | | April 24, 1918 | | 68 RS. | | | | | | | | 3-17- | | 1987 A M | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| New Jersey | | USA | | | | Baltimore City | | | | | | | | | | | |
| 11. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 501 W. Franklin St. | | Homemaker | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Anne Arundel | | Severn | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1408 Rogers Lane | | 21144 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| Michael | | Bertha | | no | | 153-07-3480 | | Michael K. Mastromarino | | 2099 Lake Grove | | Crofton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | Smoke inhalation and Arteriosclerotic | | | | | | | | | | | | | | | |
| 8902 | | Cardiovascular Disease | | | | | | | | | | | | | | | |
| Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last. | | (b) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 5:30am 3-17-87 | | Accident- Subject in house fire | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| house | | 501 W. Franklin St | | Baltimore | | MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> | | Inspection <input type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion | | | | | | | | | |
| death resulted from: | | Natural causes <input type="checkbox"/> | | Accident <input checked="" type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE
SIGNED | | 3-17-87 | | | | | | | | | |
| Dennis F. Smyth, M.D. | | Assistant | | | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | 111 Penn St., Baltol, MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Cremation | | Mar. 21 1987 | | Metropolitan Crematory | | Alexandria, Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Beall Funera l Home | | 16000 Annapolis Road
Bowie, Maryland | | MAR 23 1987 | | Julia Davidson-Rodgers | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial certificate. These instructions apply to all funeral directors. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic cause, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--------------------------------------|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
MAE T MATAROZZA | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 5, 1987 | | 2b. HOUR
8:05 PM | |
| 3 SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Oct. 14, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Choir Director | | 12b. KIND OF BUSINESS OR
OCCUPATION
Church Music | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Essex | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
800 Glass Ave. 21221 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Tutchton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gladys Curry | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
Anthony Matarozza, Husband | | ADDRESS
Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic breast CA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 mins</u>
<u>1983</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3/4</u> , 19 <u>87</u> , to <u>3/5</u> , 19 <u>87</u> , that (I) (we) <input checked="" type="checkbox"/> last saw the deceased alive on <u>3/5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Lea Stern MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<u>3/5/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>LEA STERN</u> | | | | 22e. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u>
<u>600 N. Wolfe St. Baltimore MD 21205</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<u>Burial</u> | | 23b. DATE
<u>3/9/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gardens of Faith Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore Co., Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Bruzdinski Funeral Home</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 10 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |



ET 44 475 8
 JUN 10 1961

Name: [illegible]
 Address: [illegible]
 City: [illegible]
 State: [illegible]
 Zip: [illegible]
 Date: [illegible]
 Signature: [illegible]
 Title: [illegible]

This document is the property of the [illegible]
 and should be returned to the [illegible]

047697

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07593

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Annie B Mayo | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 16 87 | | | 2b. HOUR
3⁰⁷ A.M. | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 13 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
- - - - | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
Balt. City | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
6471 Woodgreen Circle 21207 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oscar NMI Terry | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hennie NMI Cole | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO.
218-26-4365 | | | 17. INFORMANT
ADDRESS
RITA MAYO LAMBERT 6471 WOODGREEN CIRCLE | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fungal Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(b) Broad-Spectrum Antibiotic Treatment
DUE TO, OR AS A CONSEQUENCE OF
(c) Infectious Complication Site.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
3 weeks
3 weeks | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Diabetes mellitus, Renal Insufficiency, CHF & cardiomyopathy | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Mr Allan Walker MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/16/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Allan Walker, MD | | 22e. ADDRESS
Dept. of Medicine Univ. of MD Hospital 22 S. Greene St, Balt, MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-20-87 | | 23c. NAME OF CEMETERY OR CREMATORY
King MEM. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BANDOLISTOWN, MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>John F. ...</i> | | | |

11/10/19

11/10/19

11/10/19

11/10/19

11/10/19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
1 - STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 87 07594
REG. NO. | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
EMILY ELOIS MAYO | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 10 87
2b. HOUR
7:10 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 11 1930
6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LAURENCE WILLIAMS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HATTIE SNELL | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
214-26-9679 | | 13c. STREET ADDRESS / ZIP CODE
538 N. CARROLLTON AVENUE BALTIMORE, MD. 21223 | |
| 17. INFORMANT
MR. BALTIMORE, MD. 21223 | | DALLAS MAYO | | 538 N. CARROLLTON AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CEREBRAL VASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>PERIPHERAL VASCULAR DISEASE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
327 87 0310 87 | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>87</u> , to <u>03/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Kuang-yen Huang MD | | DEGREE
MD | | 22c. DATE SIGNED
03/10/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KUANG-YEN HUANG | | 22e. ADDRESS
BON SECOURS Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/14/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
KING MEMORIAL PK. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | 24. FUNERAL HOME, INC.
2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
Dorothy K. Kunkin | | | |

BP _____

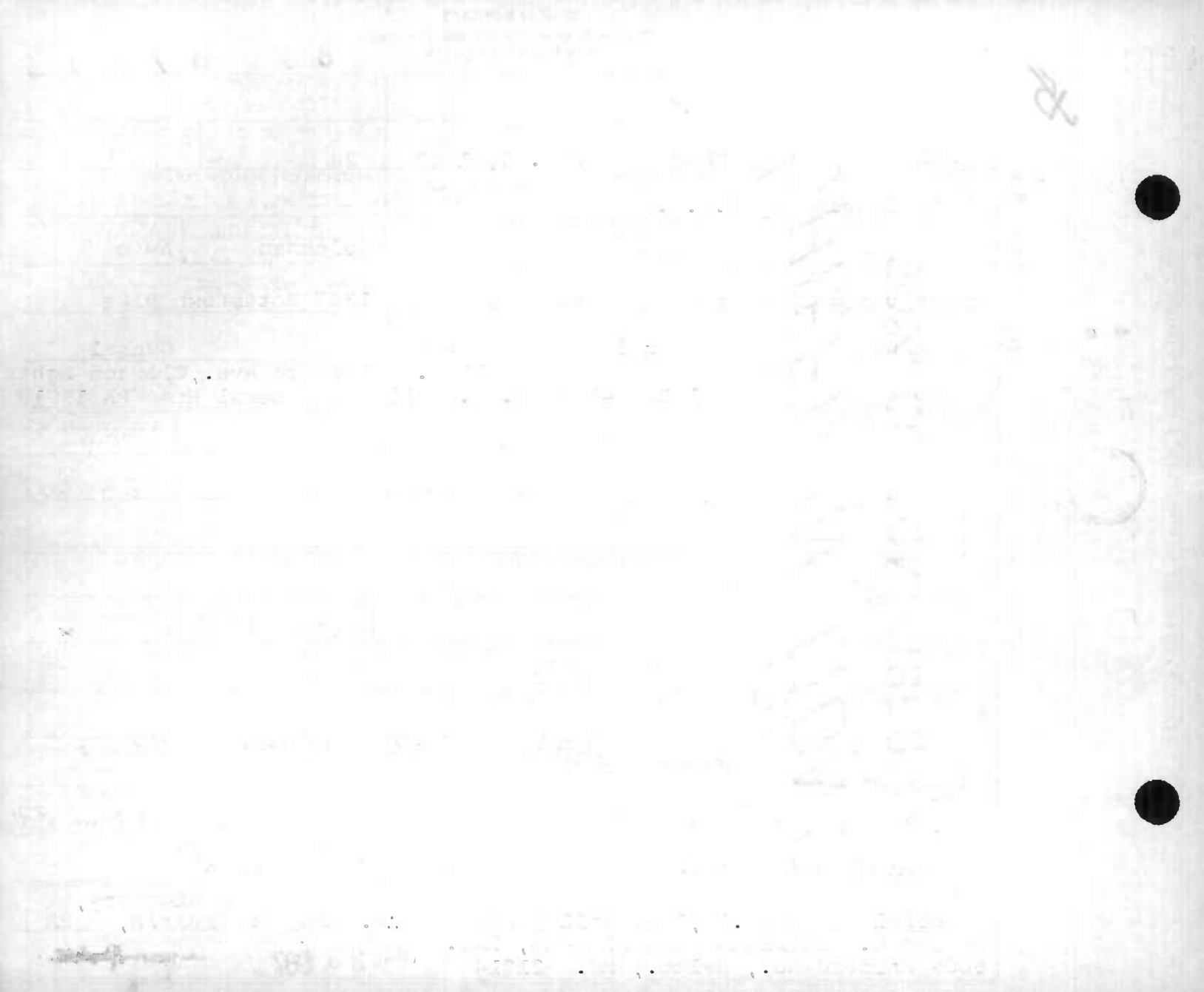
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Item # 1, Film G 626, 4/7/87 ra

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07595

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
AUSTIN D. MAZZULO | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 19, 1987 | | 2b. HOUR
1:50 AM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 3, 1962 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
24 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 72 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto | | |
| 13a. STATE
Pennsylvania | | | 13b. COUNTY
Chester | | 13c. CITY OR TOWN
Westchester | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1367 Pottstown Pike 99999 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Arthur Mazzulo | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Barbara Gungel | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
192-44-3470 | | 17. INFORMATION ADDRESS
33 W. Baltimore Ave., Clifton Hgts
M. F. Williams Funeral Home/PA 19018 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>electromechanical dissociation</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>sepsis, unknown organism</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min
2 weeks | | | | | | | | | | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>Hodgkins Disease</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <i>Feb 5</i> , 19 <i>87</i> , to <i>19 March</i> , 19 <i>87</i> , that (we) last saw the deceased alive on <i>19 March</i> , 19 <i>87</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22a. SIGNATURE
<i>David P. Carbone</i> | | | DEGREE
<i>MD PhD</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
19 March 87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID PAUL CARBONE | | | 22e. ADDRESS
600 N. WOLFE ST.
Johns Hopkins Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Mar. 24, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Valley Forge Gdns. King of Prussia, PA | | 23d. LOCATION
CITY OR TOWN STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT C. ALTENBURG FUNERAL HOME, INC. | | | ADDRESS
6009 Harford Rd., Balto., Md. 21214 | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Wendell Arnold</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07596

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Evenlyn S. McBride | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03-25-87 | | 2b. HOUR
PM AM
5:00 AM | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 05 1906 | | |
| 6. AGE
(IN YEARS LAST BIRTHDAY)
80 YRS. | | 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
S. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHN DEATON NURSING CENTER | | 12a. USUAL OCCUPATION:
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SCHOOL TEACHER | | 12b. INDUSTRY
CLARENDON CO., S. CAROLINA SCHOOLS | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK SINGLETON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANN CLARK | | 16. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO. | | 17b. SOCIAL SECURITY NO.
247-68-2453 | | 17. INFORMANT
BALTIMORE, MD, 21217
WILBUR N. McBRIDE 821 N. MONROE ST. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-25</u> 19 <u>87</u> , to <u>3-25</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3-25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>M. J. Brown</u> | | DEGREE
M.D. | | 22c. DATE SIGNED
3/25/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. J. Brown | | 22e. ADDRESS
844 N. Carroll Lane 21217 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
4/01/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
HOPKINS CEMETERY | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
CLARENDON CO., S. CAROLINA | | 24. FUNERAL HOME
NUTTER & SONS FUNERAL HOME, INC.,
2501 GWYNNS FALLS PKWY. BALTO. MD, 21216 | | | | |
| 25a. DATE REGD. BY REGISTRAR
MAR 31 1987 | | 25b. REG. NO. | | | | |

BP

4834

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
OFFICE OF THE SECRETARY
ATTENTION: Mr. [illegible]
FROM: Mr. [illegible]
SUBJECT: [illegible]

[Faint, mostly illegible text block containing several paragraphs of correspondence]

WATER

TO HOSPITAL OR ATTENDING PHYSICIAN: The low number, that the death was expected within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

8 REG. NO.

597

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT BRUCE MCBRIDE | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 20, 1987 | | 2b. HOUR
6:49P M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 16, 1987 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS 5 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
n/a | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY A.A. | | | 13c. CITY OR TOWN
Brooklyn Pk | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Bruce Alan McBride | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Judith Ann Hauser | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
---- | | 17. INFORMANT ADDRESS
Bruce A. McBride (same as 13e) | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) hypoplastic left heart syndrome 4d
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 min |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | |

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/17, 19 87, to 3/20, 19 87, that (I) (we) lost saw the deceased alive on 6:49 pm 3/20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bonnie Boyer Hudak | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/20/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Bonnie Boyer Hudak | | 22e. ADDRESS
Johns Hopkins Hospital | | | |

| | | | |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/23/87 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A.A.Co., Maryland |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce, 4001 Ritchie Hwy., Baltimore, MD | | 25a. DATE REC'D BY REGISTRAR
MAR 23 1987 | |

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These, together with the
other, are the main features of the



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07598

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Betty L. McCartin | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 21, 1987 | | 2b. HOUR
10:30 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 19, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
West Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3619 Malden Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Ritenour | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Virginia Welty | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
234 38 9213 | | 17. INFORMANT
ADDRESS
Robert T. McCartin Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) OAT CELL CARCINOMA METASTATIC
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 YR |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4:2 to 8:00, 1987, to M.M. 1987, that (I) (we) lost
saw the deceased alive on 3/12/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
G. I. Cohen | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Gary Cohen | | | 22e. ADDRESS
711 W. 40th Street 21211 | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Burial | 23b. DATE
03/25/1987 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn, Balto. Co., Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Burgee-Henss Funeral Home | | | ADDRESS
Baltimore, MD 21211 | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 |
| | | | | | 25b. REGISTRAR'S SIGNATURE
Alicia Davidson-Penderson |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician certifies that the death (certificate) has been examined and that the death was due to the cause stated on the certificate. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been examined and approved by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should retain the original of this certificate for 24 hours after death with the State Dept. of Health and Mental Hygiene. If item 21 is marked for item 21b, the funeral director must be notified of the death.

BP

DHMH - 16 60M 7/87
(VRS 15, 4)

RELEASED AS NON-MED PER MR. GREGORY & DR. KAUFFMAN, MEDICAL EXAMINER'S OFFICE

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ARTHUR McCLAIN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 11, 1987 | | 2b. HOUR
1:37 P.M. | | |
| 3. SEX
male | | 4. RACE
col | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-28-43 | | 6. AGE (IN YEARS LAST BIRTHDAY)
43 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK AND MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6028 St. Regis Rd. 21206 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Human McClain | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Parker | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO.
042-72-2084 | | 17. INFORMANT
ADDRESS
Mr. John McClain 6028 St. Regis Rd. 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) dilated cardiomyopathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Immune deficiency-retroviral infection
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min.
2 years
2 years. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/11 19 87 , to 3/11 19 87 , that (I) (we) last saw the deceased alive on 3/11 19 87 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
McBrynn | | | | DEGREE
MD | | | | 22c. DATE SIGNED
3-11-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK C. BENYUNES | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3-15-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Mt. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Cal. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ | | | | ADDRESS
2222 W. North Ave. | | 25. DATE RECEIVED BY REGISTRAR
MAR 17 1987 | | 26. REGISTRAR'S SIGNATURE
John D. Darden-Rudner | |

MSL 80 J. L. 555
RCHTAA. MIAJON
N. ENVIROF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07600 | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MAUDE Helen MCCORMICK | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 20 1987 | | 2b. HOUR
2:40am |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 3, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | 7b. CITIZEN OF WHAT COUNTRY?
USA. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
City | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Benjamin Gibson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dixie Coley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-22-4695 | | 17. INFORMANT ADDRESS
47 N. Pannery Rd.
Westminster, Md. 21157 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC SQUAMOUS CELL CANCER
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 9 , 19 87 , to MARCH 20 , 19 87 , that (I) (we) last saw the deceased alive on MARCH 20 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Paul Gormley</i> | | DEGREE
MD | | 22c. DATE SIGNED
3/20/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL GORMLEY, M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Mem. Gardens | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Carroll Md. | | 23e. NAME OF CEMETERY OR CREMATORY
Carroll Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Eckhardt</i> | | ADDRESS
Funeral Chapel
Owings Mills, Md. 21117 | | 25a. DATE RECEIVED BY REGISTRAR
MAR 20 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

BP

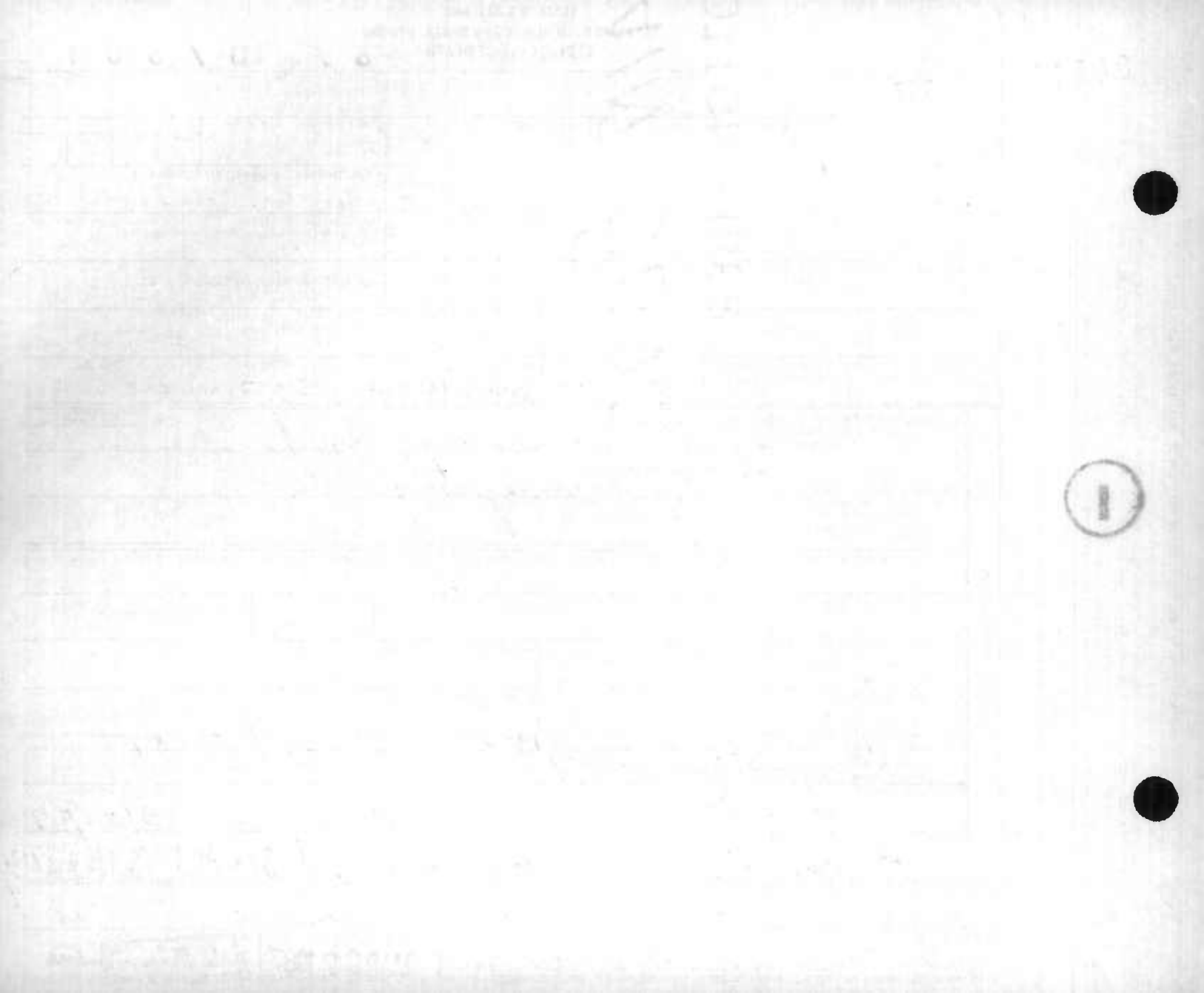
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Emma LEE MC Coy | | | | | | 20. DATE OF DEATH MONTH DAY YEAR
3 23 87 | | 26. HOUR
M | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
7 7 26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
DISAB. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WALTER ALLEN | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARTHA DOUGLASS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
238428778 | | 17. INFORMANT ADDRESS
WANDA McDougal 5403 RADICKE ST, Apt. E. 21206 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , 19 <u>3</u> / <u>1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>B. L. ...</u> | | 22c. DATE SIGNED
3/25/87 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. L. ... | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8-28-87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
LARGOWNE MD | | 23e. DATE REC'D. BY REGISTRAR | |
| 24. FUNERAL DIRECTOR NAME
MARCH FUNERAL HOME | | 24b. ADDRESS
1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |



046351 MAR 19

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A FINGERPRINT MUST BE OBTAINED FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07602 |
|---|---------|------------------|--|----------------|------|--|------|--------------------------|---|----------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR HOUR | |
| Harry Allen McCoy | | | | | | XX 3-2 1987 | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR |
| Male | Black | 12/9/1946 | 40 YRS. | MONTHS | DAYS | HOURS | MIN. | 3-2 1987 | 5:45 p. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Wayne Co., N.C. | | | U.S.A. | | | | | | Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | 823 N. Glover Street | | | Laborer | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | |
| Md | | | None | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | |
| George McCoy | | | Caldonia Williams | | | Yes # RA14943342 | | | 241-68-6864 | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| Caldonia McCoy, Goldsboro, N.C. Rt 3 Box 132A | | | PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Seizure Disorder</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Alcoholism</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| 19. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? (Head Only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 22b. ACTUAL SIGNATURE | | | 22c. DATE SIGNED | | | | |
| Dennis F. Smyth, M.D. | | | Assistant | | | 3-3-87 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | | 3/9/87 | | | Carver Mem. | | | Mount Olive, N.C. | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Law Funeral Home | | | MAR 06 1987 | | | Anita Gordon-Randall | | | | |

1

REG. NO.

MEDICAL CERTIFICATION

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or cause.

DHMH - 16 60M 7/B4
(VRA 15, 4)

100-0-15000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07604

| | | | | | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | LAST | |
| Napoleon | | Mc GILL | | 3/28/87 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| M. | | Black | | 5-09-11 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. CITIZEN OF WHAT COUNTRY? | | 8. BALTIMORE CITY OR COUNTY OF DEATH | |
| 75 YRS. | | USA | | City | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | |
| GORTON | | Baltimore, MD 21215 | | 2412 Shirley Ave. Frederick Md. Bethlehem Steel | |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. FATHER'S NAME | |
| Bethlehem Steel | | | | Napoleon | |
| 15. INSIDE CITY LIMITS? | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | 212-073357A | | Lueders 22449 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. DATE OF OPERATION | | 20. AUTOPSY? | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): | | 19 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Cardiac arrest | | 21a. INJURY OCCURRED | | 22a. DATE SIGNED | |
| DUE TO, OR AS A CONSEQUENCE OF (b): | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 3/30/87 | |
| Carcinoma of lung | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c): | | 21d. LOCATION (STREET CITY OR TOWN COUNTY STATE) | | | |
| Organic brain disease | | 21e. ADDRESS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| | | Manuel Levin MD | | 3/30/87 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 4387 | | Mt Zion | |
| 24. FUNERAL DIRECTOR (NAME) | | 24b. ADDRESS | | 25. DATE REC'D. BY REGISTRAR | |
| Arthur McLean | | 2302 W. North Ave | | MAR 30 1987 | |
| 26. REGISTRAR'S SIGNATURE | | 26b. ADDRESS | | 26c. DATE SIGNED | |
| John T. Fisher | | 2302 W. North Ave | | 3/30/87 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|--|--|
| 1. FOR REGISTRAR | | 2a. DATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2b. DATE OF DEATH | | REG. NO. | |
| WALTER | | 3/27/87 | | 07505 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Male | | Black | | MONTH DAY YEAR | |
| | | | | 1 9 03 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| S.C. | | USA | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Balto. | | Liberty Med. Center | | Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Laborer | | Beth Steel | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | | | Balto. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Sylvester | | McGill | | Irby | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 213-09-0934 | | Barbara Edwards | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 19. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| METASTATIC LUNG CANCER | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I, (this hospital) attended the deceased from 3/23, 1987, to 3/23, 1987, that (I, we) last saw the deceased alive on 3/23, 1987, and that in (my, our) opinion death occurred on the date and hour and from the causes stated above) (I, we) (did, did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| DORA S WERTHEIMER MD | | | | 3/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| DORA S WERTHEIMER | | 861 PARK AVE. BALTO. 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 4/1/87 | | Arbutus Mem. Pk. | |
| 23d. LOCATION | | 23e. CITY OR TOWN | | 23f. COUNTY | |
| Arbutus, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm C March F/H West | | 4300 Wabash Ave | | MAR 30 1987 | |

10/10/10
[Faint, illegible handwritten text follows, appearing to be a list or report.]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

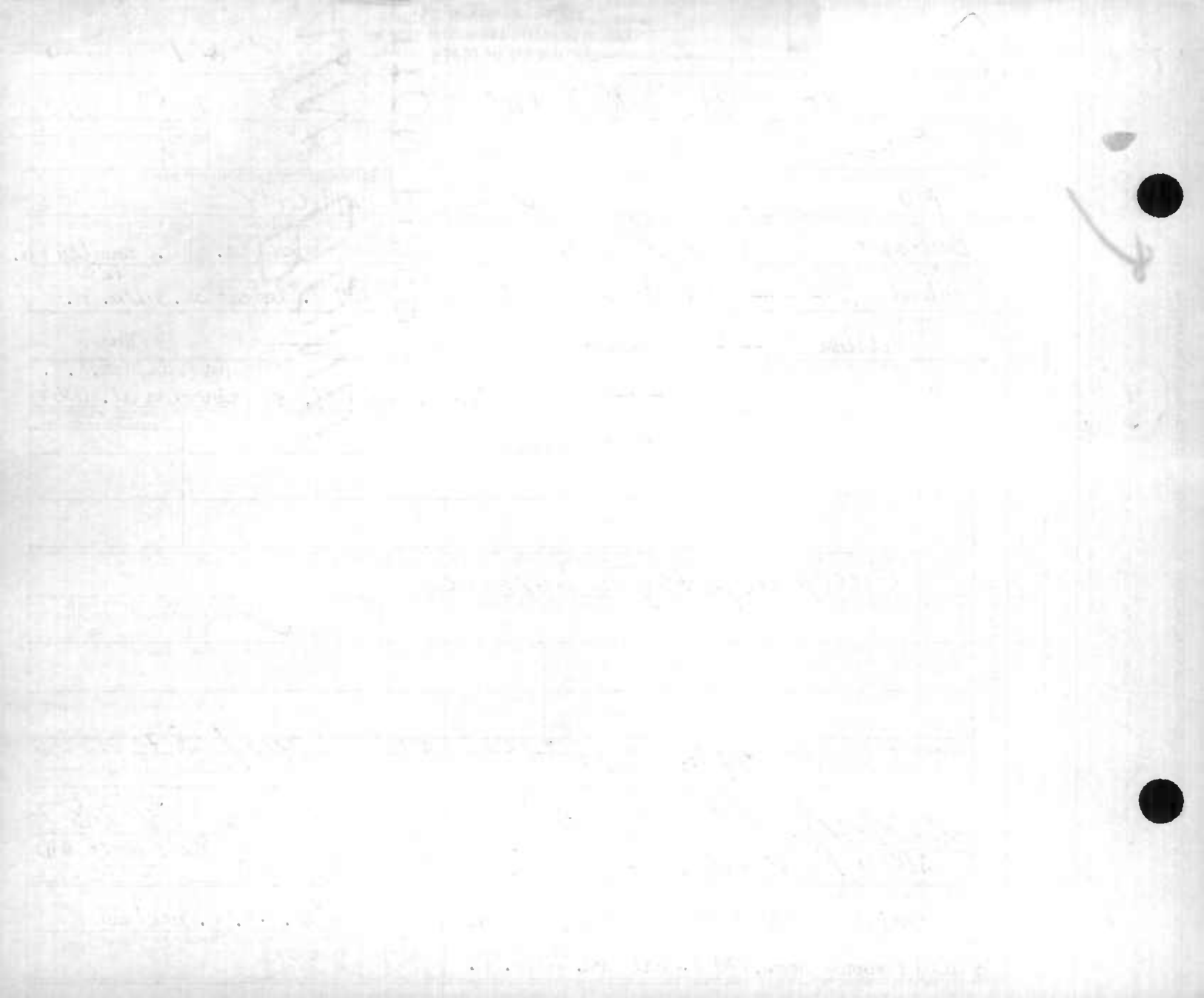
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07006 | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Corra A. McIntyre</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>03 17 87</u> | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>01 02 01</u> | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<u>86</u> YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MD</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>BALTO. CITY</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Univ. of MD.</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Key Punch Opr.</u> | |
| 12b. KIND OF BUSINESS OR INDUSTRY
<u>MD. Casualty Co.</u> | | 13a. STATE <u>Maryland</u> | | | |
| 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
<u>129 W. Clement St. Balto. Md.</u> | | 14. FATHER'S NAME FIRST MIDDLE LAST
<u>William Sanders</u> | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Mary King</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <u>No</u> | | | |
| 16b. SOCIAL SECURITY NO.
<u>217-03-3069</u> | | 17. INFORMANT ADDRESS
<u>Charles Dockendorff, 636 Princeton St. 07646</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Encephalopathy, hypoxic</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> 19 <u>87</u> to <u>3/17</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>John R. Absher MD</u> | | 22c. DATE SIGNED
<u>3/17/87</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>John R. Absher MD</u> | |
| 22e. ADDRESS
<u>22 S. Greene St. Baltimore, MD 21201</u> | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | | |
| 23b. DATE
<u>3/20/1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Balto. A.A.Co. Maryland</u> | |
| 24. FUNERAL DIRECTOR
NAME <u>McCurly Funeral Home, 130 E. Fort Ave. Balto. Md.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 19 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07607

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--------------------------------------|--|----------------------|--|---------------------------------|--|--------------------|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
John | | MIDDLE | | LAST
McKENNY | | 2a. DATE OF DEATH | | MONTH
3 | | DAY
3 | | YEAR
87 | | 2b. HOUR
12 ^{PM} | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH | | MONTH
07 | | DAY
28 | | YEAR
13 | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 73 | | 7. IF UNDER 1 YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | Baltimore City | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | Baltimore | | Bon Secours Hospital | | Butcher | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | 2746 Kinsey Avenue | | 21223 | | | | | |
| 14. FATHER'S NAME | | FIRST
William | | MIDDLE | | LAST
McKenny | | 15. MOTHER'S MAIDEN NAME | | FIRST
Mary | | MIDDLE | | LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | N/A | | 220-07-4651 | | Gertrude McKenny | | 2746 Kinsey Avenue | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular tachycardia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Ischemic Heart Disease

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Septemuria BSKD

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | |
| 22a. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 22c. LOCATION (STREET CITY OR TOWN COUNTY STATE) | | | |
| 23a. I certify that (I) (this hospital) attended and deceased from 2/24 19 87 to 3/3 19 87 that (I) (we) last saw the deceased alive on 3/3 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, I did not see the body after death.) | | 23b. SIGNATURE
J. BELTRAN | | 23c. DEGREE
MD | | 23d. ADDRESS
1940 W. BALTIMORE ST | |
| 23e. PHYSICIAN'S NAME (Type in print) | | 23f. ADDRESS | | 23g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 23h. DATE SIGNED
3/3/87 | |

| | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
03-07-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | 23d. LOCATION
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Brown/Thompson Funeral Home | | ADDRESS
1913 W. Baltimore St. | | 25. DATE RECD. BY REGISTRAR
MAR 05 1987 | | 25. REGISTRAR'S SIGNATURE
Julia Borden | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Department of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Maryland 21201.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

McKenney
337 154

Male Black



048834 APR

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THE MEDICAL EXAMINER ALONG WITH THE REGISTRAR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC'D 07608

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|----------------------------|--|------------------|--|--------------------------------------|--|-------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| CHARLES H. MCKENZIE | | | | | | | | 3-27-87 | | 19 | | | | | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | | White | | June 30 19 | | 67 YRS. | | | | | | 3-27-87 | | 19 | | | | | | 2:17P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | USA | | | | | | | | | | Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | Maryland General Hospital | | Sheet Metal Worker | | Self-Employed | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Maryland | | Baltimore | | Arbutus | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4835 Carmella Drive, 21227 | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| James Leo McKenzie | | Clara Louise Saunders | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| Yes | | WW II | | 213-12-7178 | | Lenora M. McKenzie, 4835 Carmella Drive | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | | | |
| <i>Margaret A. Korell</i> | | Assistant | | 3-29-87 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| Burial | | 3/31/87 | | Crownsville VA Cemetery | | Crownsville A.A. Maryland | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Hubbard Funeral Home, Inc., | | 4107 Wilkens Ave. | | MAR 30 1987 | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07609

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST EDWARD MIDDLE BENSON LAST MCKENZIE
<i>EDWARD MCKENZIE</i> | | 2a. DATE OF DEATH
MONTH 3 DAY 7 YEAR 87
<i>3 7 87</i> | | 2b. HOUR
<i>707 A</i> | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 6 DAY 29 YEAR 13
<i>6 29 13</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Florida | | 13b. COUNTY
Pinellas | | 13c. CITY OR TOWN
Tarpon Springs | |
| 14. FATHER'S NAME
FIRST John MIDDLE MCKENZIE LAST MCKENZIE | | 15. MOTHER'S MAIDEN NAME
FIRST Helen MIDDLE PARROTT LAST PARROTT | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 714-05-6875A | | 17. INFORMANT
Mrs. Daisy V. McKenzie Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <i>1/23</i> 19 <i>87</i> to <i>3/7</i> 19 <i>87</i> , that (1) <i>last</i> saw the deceased alive on <i>3/7</i> 19 <i>87</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>we</i> (I) (did) (do) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>AP Marco MD</i> | | DEGREE | | 22c. DATE SIGNED
<i>3/7/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>A P MARCO</i> | | 22e. ADDRESS
<i>4940 Eastern Ave Baltimore MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Olivet Cemetery | |
| 23d. LOCATION
CITY OR TOWN
St. Michaels | | COUNTY
BEECH | | STATE
Maryland | |
| 24. FUNERAL DIRECTOR
NAME
<i>Leroy M. & Russell C. Witzke</i> | | ADDRESS
<i>1630 Edmondson Avenue, Catonsville, MD. 21228</i> | | 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07610

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES M MCLAIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 8, 1987 | | | 2b. HOUR
4:05 pm | | | |
| 3. SEX
Male | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 7 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2660 WEST NORTH AVE. 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ELMORE MCLAIN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAE HELEN NEWMAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO. | | 16b. SOCIAL SECURITY NO.
216-14-4375 | | 17. INFORMANT
MAE H. MCLAIN | | ADDRESS
2660 WEST NORTH AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis

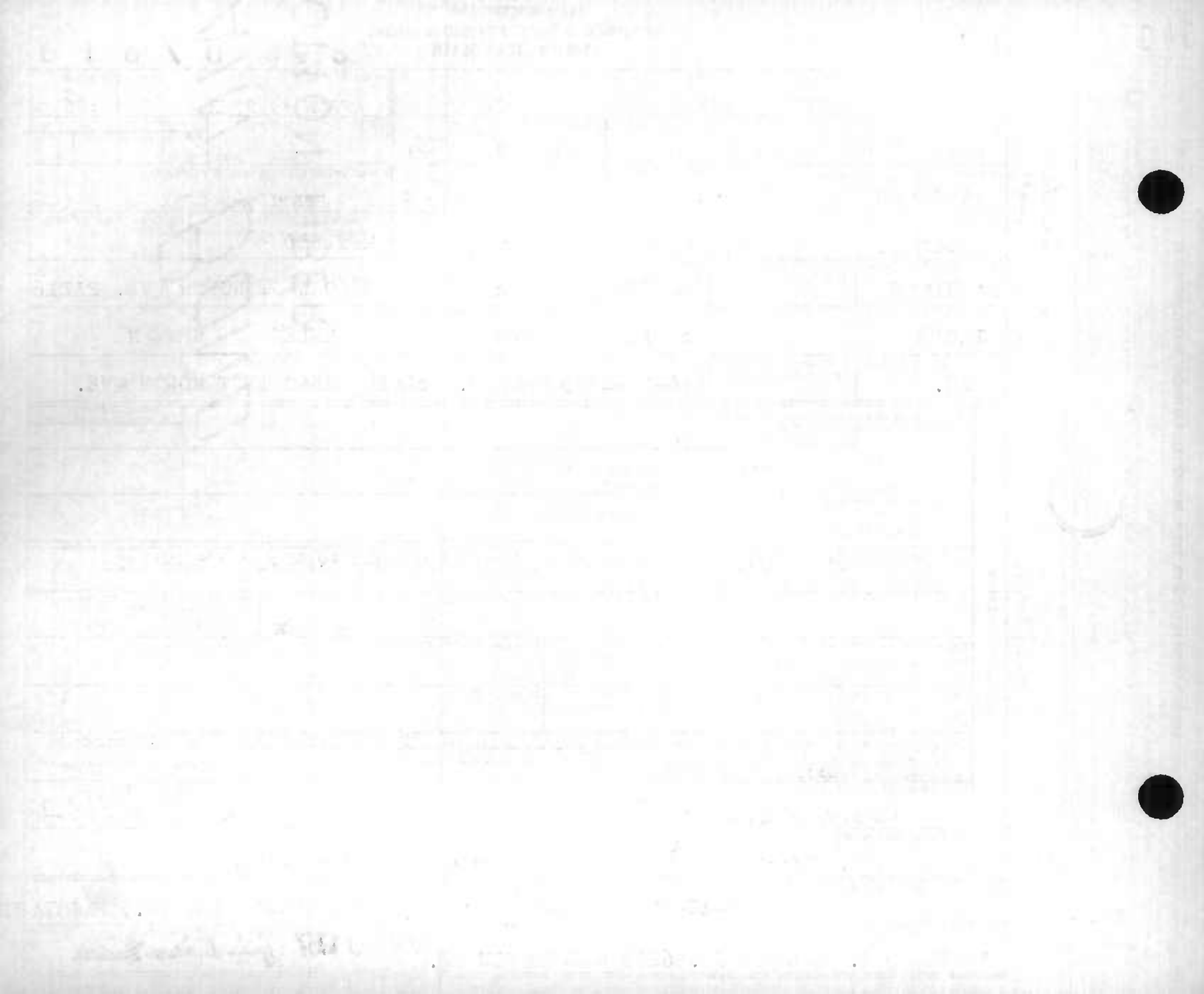
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
Hypertension; Arterial Sclerotic Vascular Disease; History of Atrial Fibrillation; Adult of Set Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1987 to March 8, 1987 . I saw the deceased alive on March 8, 1987 , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Fuad Shihab MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Shihab | | | | 22e. ADDRESS
Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3-12-87 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN, CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE (BALTO.) MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
WINFIELD E. FREEMAN JR. | | | | ADDRESS
6205 CHINQUAPIN PK. | | 25a. DATE REC'D BY REGISTRAR
MAR 10 1987 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Benson-Radner | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked off, item 18 shows body injury, or other significant event, the medical examiner must be notified.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 87 REG. NO. 07611 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Shirley Mcneil | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 4 87 | | 2b. HOUR
440 A.M. | | | |
| 3 SEX
F | | 4 RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
4 6 28 | | 6 AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTTEKEY HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
ROSCOF | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JUANITA | | 13e. STREET ADDRESS / ZIP CODE
913 S. KENWOOD AVE 21224 | | 13f. STREET ADDRESS / ZIP CODE
913 S. KENWOOD AVE 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-22-8717 | | 17 INFORMANT
DEBORAH MCNEIL | | 17 ADDRESS
913 S. KENWOOD AVE 21224 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast cancer with numerous metastases</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>12 years</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
one minute | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER): | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/3 19 87, to 3/4 19 87, that (I) (we) last saw the deceased alive on 3/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Hillel Grossman MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Hillel Grossman | | | | 22e. ADDRESS
Francis Scott Key | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NAT'L CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR NAME
LILLY & ZEILER, INC. | | | | 24b. ADDRESS
21231 | | 24c. DATE REC'D BY REGISTRAR
MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE | |

049443 APR 08

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the physician after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to file.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|---------|--|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR |
| Baby GIRL "B" (BROWN) | | | | | 3 31 87 | | | | | 746A M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| Female | Black | 3 24 87 | | — | | YRS. 7 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MD. | | | | |
| Maryland | | USA | | | | Baltimore City | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | St. Agnes Hosp. | | | | — | | — | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE Maryland 13b. COUNTY — 13c. CITY OR TOWN Baltimore | | | | | | | 2806 Denham Circle 21225 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Roderick C. McNeill | | | | | Jacqueline Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | | — | | Jacqueline Brown 21225 2806 Denham Circle | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) INTRAVENTRICULAR HEMORRHAGE | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) EXTREME IMMATURITY | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | 746 P.M. 3/31 87 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| ARTURO Q. SANTOS | | | | | | | | 3/31/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| ARTURO Q. SANTOS | | | | | 900 Caton Ave BALTO MD 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 4/3/87 | | Cedar Hill Cem. | | | Glenn Burnie, Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | APR - 2 1987 | | Julia Gordon-Randall | | | |

4/10

047033 MAR 12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

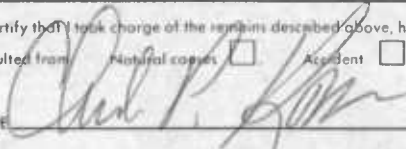
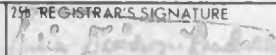
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

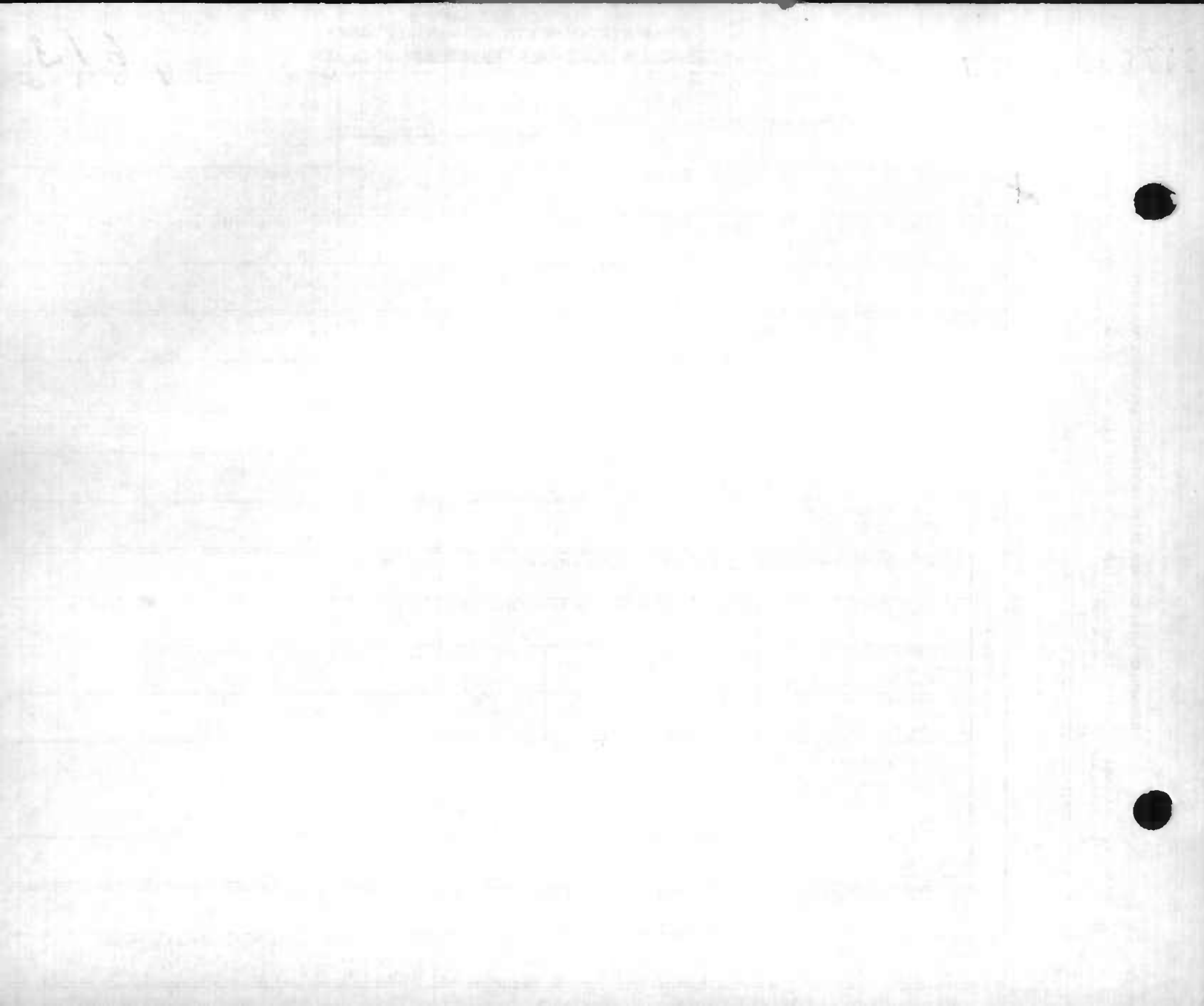
07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

613

| | | | | | | | | | | | | | | | |
|--|--|--------------|--|--|--|---|--|--|--|---|--|---|--|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Rodney EDWARD Meadows | | | | | | | | | | 2b. DATE KNOWN OF DEATH
MONTH DAY YEAR
3/ 7/ 19 87 | | 2c. DATE OF ESTI- MATED DEATH
MONTH DAY YEAR
3/ 7/ 19 87 | | 2d. HOUR
8:17
P M | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 30 66 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) MONTHS DAYS HOURS MIN
20 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3/ 7/ 19 87 | | 7d. HOUR
8:17
P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMP. | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21218
704 CHESTNUT HILL AVE | | | | | |
| 14. FATHER'S NAME
(FIRST) MIDDLE LAST
RONALD MEADOWS | | | | 15. MOTHER'S MAIDEN NAME
(FIRST) MIDDLE LAST
BEULAH NEAL | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
215860168 | | | |
| 17. INFORMANT
ADDRESS
21218
RONALD MEADOWS 704 CHESTNUT HILL | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE OR UNDERLYING CONTRIBUTING CAUSE OF DEATH
<input checked="" type="checkbox"/> OR
<input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MIN MONTH DAY YEAR
7:15 M. 3/ 7/ 19 87 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject shot | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
basement of | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1729 Ashland Ave., Balto. City, Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from _____
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
3/8/87 | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
3/13/87 | | 23c. NAME OF CEMETERY OR CREMATORY
KING MEMORIAL PK | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RANDALLSTOWN MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME | | | | ADDRESS
1101 E. NORTH AVE. | | | | 25a. DATE REC'D BY REGISTRAR
MAR 12 1987 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be related by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Their please remove the top portion. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 / REG. NO. 07614 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>ROGGIE Lee Medaniel</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>2 19 87</i> | | 2b. HOUR <i>M</i> | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>7 4 21</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secour Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Disabled</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> | | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <i>Fred Hardin</i> | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>Wardel Crosby</i> | | 13e. STREET ADDRESS / ZIP CODE <i>2324 Ashland Ave 21205</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>N/A</i> | | 17. INFORMANT, ADDRESS <i>Gloria Bullock 1100 Barday St</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>(1) Pneumonia (2) CHF (3) Septicemia (4) ARDS (5) UOD</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12/5 19 86 P.M.</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/5 19 86</i> to <i>2/19 19 87</i> that (I) (we) lost saw the deceased alive on <i>2/19 19 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | 22c. DATE SIGNED <i>2/20/87</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>2/25</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto MD</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>Wm. C. March F.H.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 25 1987</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

180



[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07615 | |
|--|--|---|---------------------------|---|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 87 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
BINAH MEIZLISH | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 / 1 / 87 | | | 2b. HOUR
12 37 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
04 01 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
59 94 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital of Baltimore | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md. | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
BENZION BRONFEIN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
RISSEL UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
216-36-1176 | | 17. INFORMANT MR. BERNARD MEIZLISH
2 BRIDLEWOOD CT. OWINGS MILLS, MD 21117 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Pulm Edema,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) CHF 2° to A fib
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/01/87, 19 87, to 3/1, 19 87, that (I) (we) last saw the deceased alive on 2/1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Honnie Draper | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
3/1/87 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Honnie Draper | | | | | 22e. ADDRESS
Sinai Hospital of Baltimore, Belvedere | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
MAR. 2, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
SWINICHER WOLINER BENEV. ASSOC. BALTO. MD | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 05 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

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049926 APR 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the Division of Vital Records, Department of Health and Mental Hygiene, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or inhumation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 REG. NO. 07616 | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MENSAH BABY GIRL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02/26/87 | | 2b. HOUR
DAY MONTH
0130 M |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
02/25/84 | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
1 42 | | IF UNDER 1 YEAR
IF UNDER 24 HRS. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
B. cit MD | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
C | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4617, Manordene Rd B. md 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
--- | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LILLIAN MENSAH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
--- | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
ADDRESS
4617, Manordene Rd B. md 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) NON VIABLE (23 weeks gestation fetus)
DUE TO, OR AS A CONSEQUENCE OF (b) PREMATURITY
DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLY MATERNAL INFECTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/25/87 19 87 , to 2/26 19 87 , that (I) (we) last saw the deceased alive on 2/26 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
St. Agnes Hosp | | 22c. DEGREE
MD | | 22d. DATE SIGNED
2/26/87 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
C.F. DOS SANTOS | | 22f. ADDRESS
St. Agnes Hosp | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | |
| 23d. LOCATION
BALTIMORE, MD. 21229 | | 23e. STATE
MD | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, 4107 WILKENS AVE. | | 24a. DATE REC'D. BY REGISTRAR
APR 07 1987 | | 24b. REGISTRAR'S SIGNATURE
John D. ... | |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained for 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers, place in envelope, and mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MARGARET MIDDLE Frainie LAST MENTON | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Margaret | | Menton | | 3 13-87 | | 3:45 P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. YRS | |
| FEMALE | | WHITE | | 7 17 1907 | | 79 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | | | BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | KESWICK - 700 W. 40th ST. BALTO. MD. | | Exec. Sec. Ret. | | M.S.L.B.A. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Baltimore | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 236 Rogers Forge Rd. 21212 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| FRANK | | MARGARET | | | | 215-42-6639 | | John A. Menton III | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| PART I. DEATH WAS CAUSED BY: | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| IMMEDIATE CAUSE (a) Cor pulmonale | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Advanced COPD | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | HOUR A.M. MONTH DAY YEAR | | | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | |
| 21a. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | P.M. 19 | | | | 21f. STREET | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 14, 1985, to March 13, 1987, that (I) (we) last saw the deceased alive on March 13, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. ADDRESS | | 22e. REGISTRAR'S SIGNATURE | | 22f. REGISTRAR'S SIGNATURE | |
| M. Isabelle MacGregor | | 3-13-87 | | KESWICK, 700 W 40th STREET, BALTO MD 21211 | | John A. Menton III | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. DATE SIGNED | | 22d. ADDRESS | | 22e. REGISTRAR'S SIGNATURE | | 22f. REGISTRAR'S SIGNATURE | |
| M. ISABELLE MacGREGOR | | 3-13-87 | | KESWICK, 700 W 40th STREET, BALTO MD 21211 | | John A. Menton III | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. COUNTY | |
| Burial | | 3/16/87 | | New Cathedral Cemetery | | Balto. | | Maryland | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | |
| NAME Mitchell-Wiedefeld | | MAR 16 1987 | | John A. Menton III | | John A. Menton III | | John A. Menton III | |
| ADDRESS 6500 York Rd. 21212 | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be examined by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07818

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Robert MEREDITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 25, 1987 | | 2b. HOUR
11:50A_M | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 28 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
514 Cathedral St. 21201 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unkn. | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-09-2291 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis of undetermined origin
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Severe Dehydration; Renal Failure; Respiratory arrest | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 25, 1987 , to March 25, 1987 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 25, 1987 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jyoti Parikh, MD
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
3/25/87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jyoti Parikh MD | | | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
3-30-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 03 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

4/9



APR 8 1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|---|--|---------------|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| REG. NO. 07619 | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
John Franklin Merkle | | | | | 2a. DATE OF DEATH
March 1, 1987 | | 2b. HOUR
M | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
Oct. 16, 1910 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Div. Sales Manager | | 12b KIND OF BUSINESS OR INDUSTRY
C.F. Muller | |
| 13a STATE
Maryland | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
3214 Overland Avenue 21214 | |
| 14 FATHER'S NAME
George Merkle | | | | | 15. MOTHER'S MAIDEN NAME
Ella Balliett | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
190-05-4466 | | 17 INFORMANT ADDRESS
Mrs. Dorothy L. Merkle same as 13e | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>rupture aortic aneurysm,</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>MI.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hr. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (this hospital) attended the deceased from 19 80, to 3/1 19 87, that (we) last saw the deceased alive on 2/16 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E. Lee Robbins | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/0/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. Lee Robbins, M.D. | | | | 22e. ADDRESS
1205 York Road Lutherville, MD 21093 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Entombment | | 23b. DATE
03/05/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Timonium, Maryland | | | |
| 24 FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, MD | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 03 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ANDREW W. MERLE, JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 10 87 | | 2b. HOUR
2:30A M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 21, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive | | 12b. KIND OF BUSINESS OR INDUSTRY
Wholesale |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. CITY OR TOWN
Balto. | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Andrew W. Merle | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Wippert | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II | | 16b. SOCIAL SECURITY NO.
215 09 7881 | | 17. INFORMANT
ADDRESS
Ned Obrecht, Balto., MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Lung CANCER
DUE TO, OR AS A CONSEQUENCE OF
(c) 2 1/yr | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
MINUTES |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
COPD, a-fib, SVT, CHF. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 5, 19 87 , to MARCH 10, 19 87 , that (I) (we) last saw the deceased alive on MARCH 10, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Mark Clinton | | DEGREE
M.D. | | 22c. DATE SIGNED
3/10/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Clinton, M.D. | | 22e. ADDRESS
Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
3/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | |
| 4905 York Road Balto., MD 21212 | | | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rudolph | |

MEDICAL CERTIFICATION

BP

1944 10 22 2104

W. J. 1944 10 22 2104

1944 10 22 2104

Executive
1944 10 22 2104

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate is extended - from 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, and 4 and place them in the box provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be included at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07621 | |
|--|--|--|--|---|--|--|--|--|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CAROLYN Virginia MERSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 31, 1987 | | | 2b. HOUR
10:45P | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-24-1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Sales Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Florist | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5308 Grindon Ave. 21214 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown Hudgins | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown Hudgins | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-01-9314 | | 17. INFORMANT ADDRESS
Ruth L. Rowley, Same as 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>metastatic gastric carcinoma</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 minute</u>
<u>3 minutes</u>
<u>3 years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<u>dehydration, malnutrition</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> 19 <u>87</u> to <u>3/31</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>E. Serrin Gantt</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3/31/87</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>E. Serrin Gantt</u> | | | 22e. ADDRESS
<u>600 N WOLFE ST
Johns Hopkins Hospital</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 2 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Don. Ruck</u> | | | | |

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FEB
07/

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07622

| | | | | | | | |
|--|-----------|---|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| EDWARD | | JOSEPH MEYERS | | March 3, 1987 | | 12:15 ^P M. | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| MALE | CAUCASIAN | Dec. 9, 1918 | | 68 | | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTIMORE | | U.S.A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | 1710 LANCASTER STREET | | LONGSHOREMAN | | MARITIME | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
(FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME
(FIRST MIDDLE LAST) | | 13e. STREET ADDRESS | | | |
| THEODORE MEYERS | | CLARA SCHMIDT | | 1710 LANCASTER STREET 21231 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| NO | | 219-01-2447 | | BEATRICE A. MEYERS 1710 LANCASTER ST. 21231 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE RESP FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE COPD</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF UPPER LUNG</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) <u>Dr. Madura</u> attended the deceased from <u>Feb 21st</u> , 19 <u>87</u> , to <u>March 3rd</u> , 19 <u>87</u> , that (I) <u>last</u> saw the deceased alive on <u>Feb 21st</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If true, did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Dr. Madura</u> | | M.D. | | | | 3/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| DR. MADURA PRABHAKAR M.D. | | 333 S. EAST AVE. 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 3/6/87 | | ST. STANISLAUS CEMETERY | | BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| George A. Weber & Sons Inc. 705 S. Ann St. 21231 | | MAR 04 1987 | | <u>Indira Khandas</u> | | | |

048484 MAR 30

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07623

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GOLDIE | | FIRST MICHAELSON | | MIDDLE | | LAST | | 2a. DATE OF DEATH
MONTH 3 DAY 19 YEAR 87 | | 2b. HOUR
1145 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 2 DAY 19 YEAR 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO, MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
BOOKKEEPER | | 12b. KIND OF BUSINESS OR INDUSTRY
ACCOUNTING | | | |
| 13a. STATE
MD | | 13b. COUNTY
B. | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
APT. 204 6318 GREENSPRING AVE | | ZIP CODE
#21209 | |
| 14. FATHER'S NAME
FIRST ABRAHAM MIDDLE STETTIN LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST IDA MIDDLE ROSEN LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-03-7653 | | 17. INFORMANT MRS. DEBORAH ROFFMAN
6500 STEERFORTH CT. BALTO., MD 21209 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION
3/19-87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CORONARY ARTERY DISEASE | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/19/87 , 19____, to 3/19/87 , 19____, that (I) (we) lost saw the deceased alive on 3/19/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert Appelbaum | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/19/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT APPELBAUM | | | | 22e. ADDRESS
22 S GREENE ST | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAR. 22, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
HAR SINAI BENEV. SOC. | | 23d. LOCATION
CITY OR TOWN ROSEDALE COUNTY BALTO. STATE MD | | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS, INC.
NAME ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

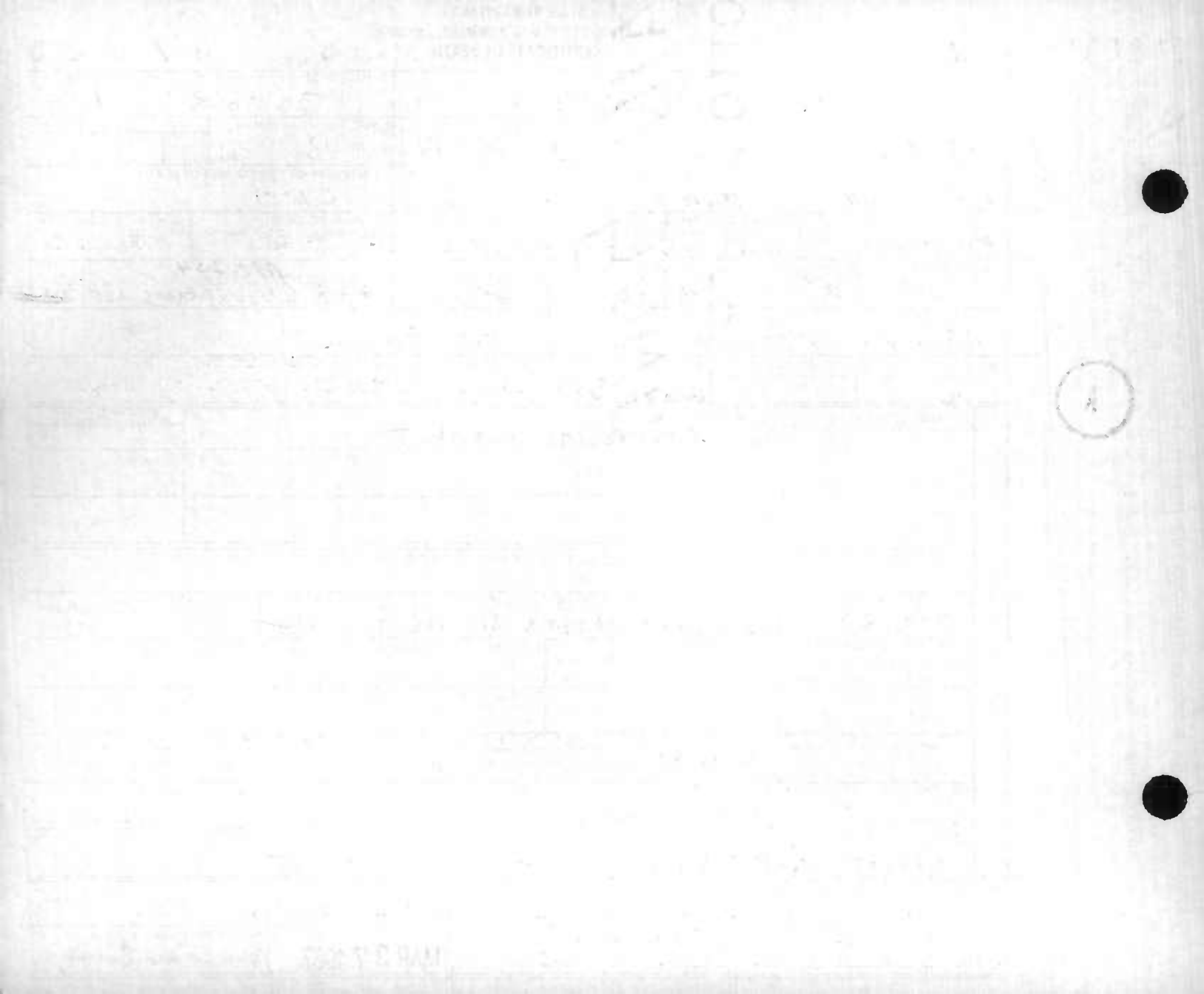
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be filed with the State Dept. of Health and Mental Hygiene prior to the funeral, cremation, or removal.

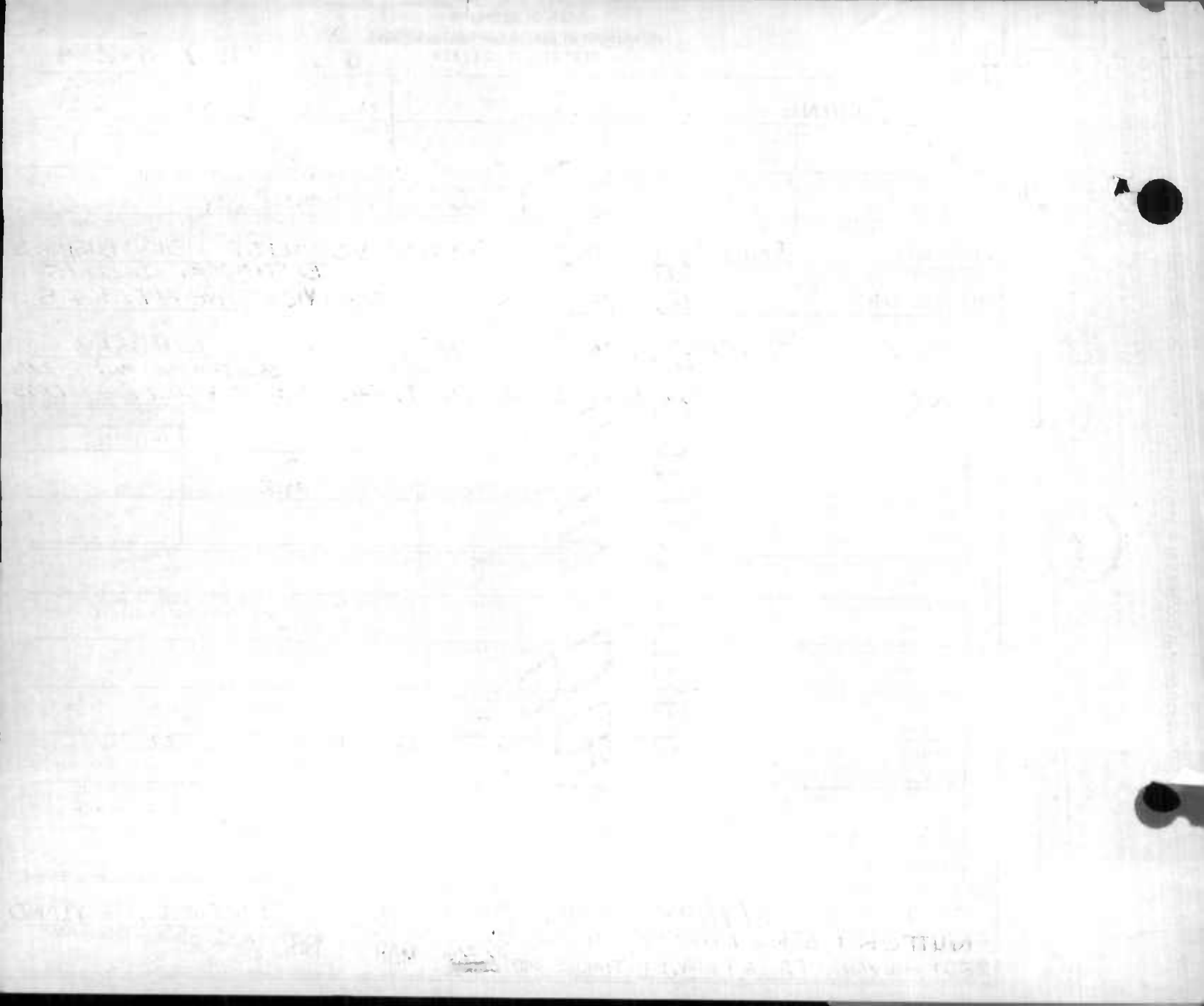
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07624

| | | | | | | | |
|---|--|--|---|---|-----------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ELAINE E. Middleton | | | | March 3, 1987 | | 2:23 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| female | Black | 4 2 23 | | 63 | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | USA | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | JOHN DEATON MEDICAL CENTER | | VOCALIST | | SHOW BUSINESS | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | BALTIMORE, MO. 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. SOCIAL SECURITY NO. | | | |
| CHARLES T. MIDDLETON | | ETHEL M. LINDSAY | | 219-16-4816 | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 17b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | 219-16-4816 | | MARLENE I. BARRETT 2503 VIOLET AVE. APT. 803 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>squamous cell carcinoma of oropharynx</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 27</u> , 19 <u>87</u> , to <u>March 3</u> , 19 <u>87</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>March 3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Maria E. Delgado M.D. | | | | 3-3-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Maria E. Delgado M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 3/17/1987 | | ARBUTUS MEMORIAL PK | | BALTIMORE, MARYLAND | |
| 24. FUNERAL HOME NAME | | 24b. ADDRESS | | 25. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| MUTTER & SONS FUNERAL HOME, INC. | | 2501 GWYNNS FALLS PKWY, BALTIMORE, MD. | | MAR 11 1987 | | John P. [Signature] | |

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07625

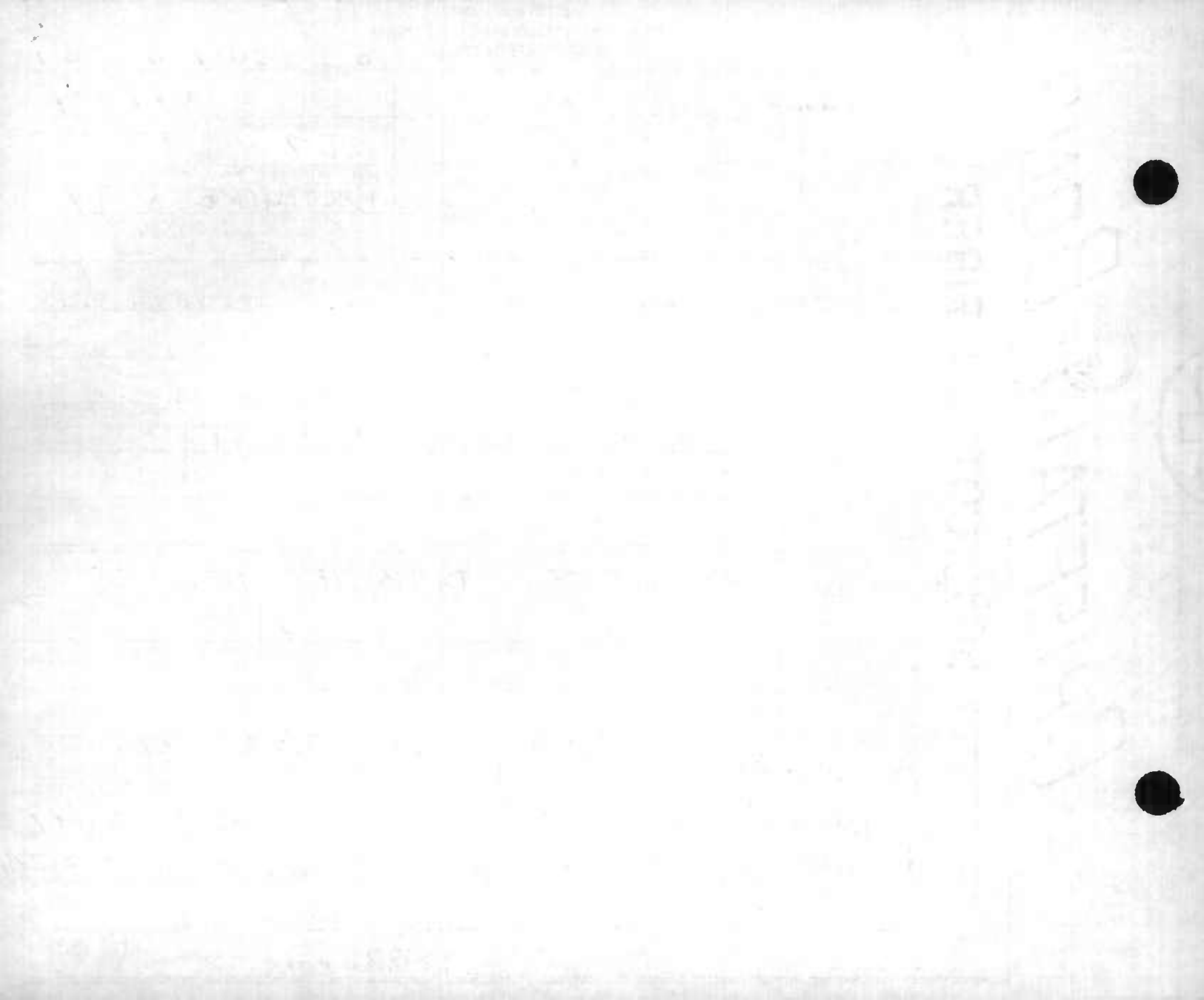
| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILDRED ADELINE MILBY | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 23 87 | | 2b. HOUR
3 ²⁰ A ^M | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
7 3 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John E. Walters | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Sigwart | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
213-03-0237 | | 17. INFORMANT ADDRESS
Rubylee Brophy 4718 Middle Ct. 21043 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>INSULIN DEPENDENT DIABETES MELLITUS</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> 19 <u>87</u> , to <u>3/23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Christine C. Harter</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>3/23/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>CHRISTINE C. HARTER</u> | | 22e. ADDRESS
<u>4940 EASTERN AVE BALT 21224</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | 23b. DATE
<u>3/25/87</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore Maryland</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Hubbard Funeral Home, Inc.</u> | | ADDRESS
<u>4107 Wilkens Ave.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 26 1987</u> | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO.

07026

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
PRISCILLA J. MILES | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 12 87 | | 2b. HOUR
11²⁰ P M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 27, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Keswick Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker. | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
MD | | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Wilbur Jester | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Minnie Sommers | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214 74 1194 | | 17. INFORMANT ADDRESS
Miss Priscilla L. Miles, Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Congestion
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Decompensation | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hr
12 hour
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (P) (this hospital) attended the deceased from 8-26 , 19 80 , to 3-12 , 19 87 , that (I) (we) last saw the deceased alive on 3-12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3-13-87 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
3/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | |
| 23d. LOCATION
CITY OR TOWN
Balto., | | COUNTY
MD | | STATE | |
| 24. FUNERAL DIRECTOR NAME
Henry W. Jenkins & Sons Co. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | |
| ADDRESS
4905 York Road Balto., MD 21212 | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

2
9

1

10247



U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY

WASHINGTON, D. C.

February 1, 1917

Dear Sir:

I have the honor to acknowledge the receipt of your letter of January 31, 1917, in relation to the matter of the proposed amendment to the regulations governing the issuance of permits for the exportation of certain agricultural products.

The matter is being considered by the Bureau and a decision will be rendered as soon as possible.

Very respectfully,
Assistant Secretary

Enclosed for you are two copies of the proposed amendment to the regulations.

Very truly yours,
Assistant Secretary

Enclosure

Very truly yours,
Assistant Secretary

Very truly yours,
Assistant Secretary

Very truly yours,
Assistant Secretary

Very truly yours,
Assistant Secretary

Very truly yours,
Assistant Secretary

Very truly yours,
Assistant Secretary

Very truly yours,
Assistant Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. This certificate is not to be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 07621 | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | LEHMAN MILLER | | 2a. DATE OF DEATH | | 3 3 87 | | 3 ²⁹ PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | 7. IF UNDER 1 YEAR | |
| M | | B | | 2 15 21 | | 66 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. BALTIMORE CITY OR COUNTY OF DEATH | |
| N.C. | | USA | | | | Balto. City | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| DARTMOUTH | | GOOD SAMARITAN HOSP | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MD | | BALTO. | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21206 5206 KENWOOD AVE. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| ANDREW | | LILLIE | | N/A | | 239-30-88804 | | ANDREW MILLER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF | | 21. DUE TO, OR AS A CONSEQUENCE OF | | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Congestive heart failure | | | | Coronary atherosclerosis | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2 | | AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | CITY OR TOWN COUNTY STATE | |
| | | P.M. 19 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| 2/21/87 | | [Signature] | | 3/10/87 | | HOLAS SCUNARINE | | 5010 York Road, BAL 2122 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | |
| Burial | | 3-11-87 | | MT. ZION CEM. | | BALTO. | | MAR 11 1987 | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | 24c. REGISTRAR'S SIGNATURE | | 24d. REGISTRAR'S SIGNATURE | |
| MARCH FUNERAL HOME | | 1001 E. NORTH AVE | | | | Julia Dendron-Randall | | | |

200 COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

BP

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 REG. NO. 07628 | |
|--|--|---|--|--|--|
| 1. DECEASED NAME FIRST MIDDLE LAST
MARGARET T. MILLER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
03 30 87 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
9 28 16 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen Hosp. | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
FRANK DEMARCO | | 15. MOTHER'S NAME FIRST MIDDLE LAST
MARIE CONNOLLY | | 16. ADDRESS
GLYNDON 2123
1229 GLENN AVE. | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 17b. SOCIAL SECURITY NO.
214144729 | | 17. INFORMANT
Hosp. record. 3001 S HANOVER ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ACUTE MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>HYPERTENSIVE CARDIOVASCULAR DISEASE.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> 19 <u>87</u> to <u>3/30</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3/30</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
(above) (below) (did) (did not) see the body after death. | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | 22c. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED
3/30/87 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
JEWELL WONG MD. | | 22f. ADDRESS
3001 S. HANOVER ST. BALT. MD 21230. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-2-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Brompton Cem | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. | | 23e. DATE REC'D. BY REGISTRAR
APR 01 1987 | | | |
| 24. FUNERAL DIRECTOR NAME
<i>[Signature]</i> | | 25. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

RECEIVED

APR 1 1961

FROM

TO

SUBJECT

REMARKS

DATE

INITIALS

SIGNATURE

APPROVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from the certificate, and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07629

FOR
1. STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary Frances Miller | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 30 1987 | | 2b. HOUR
8:35P M |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
1 16 20 | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MD. GENERAL HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MELVIN PEARSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESTELLA WOODSON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212124734 | | 17. INFORMANT
ADDRESS
JAMES MILLER JR. 1615 EUTAW PLACE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest Secondary to</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Terminal Lung Carcinoma With Metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>And severe Cardiac Arrhythmia</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 23</u> , 19 <u>87</u> , to <u>March 30</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on <u>March 30</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Chu-Huang Chen M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>CHU-HUANG CHEN, M.D.</u> | | 22e. ADDRESS
<u>Maryland General Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
4/6/87 | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS MD | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME | | ADDRESS
1101 E. NORTH AVE | | 25a. DATE REC'D. BY REGISTRAR
APR 1 1987 | |

1294

048864 APR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place in the appropriate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ROMULUS Shafter MILLER Jr. | | | | | 2a. DATE OF DEATH
MONTH 3 DAY 29 YEAR 87 | | 2b. HOUR
8:25 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 1 DAY 1 YEAR 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | | | 12a. USUAL OCCUPATION
(TYPE BY WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Pennville Steel | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7902 St. Claire Lane 21222 | | |
| 14. FATHER'S NAME
FIRST Romulus MIDDLE Shafter LAST Miller Sr. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Lexie MIDDLE LAST Linderman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES) W.W. 2 | | 17. INFORMANT ADDRESS
Margaret M. Miller 7902 St. Claire Lane 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADVANCED RECURRENT METASTATIC CANCER OF COLON
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 28 19 87 , to MARCH 29 19 87 , that (I) (we) last saw the deceased alive on MARCH 29 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) find the body after death. | | | | | | | | | |
| 22b. SIGNATURE
A. P. Helou, M.D. DEGREE | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-29-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ABDALLAH HELOU | | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 n. XXXXXX BROADWAY BALTO. MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN Eastwood, Balto. Co., Md. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 31 1987 John Davidson-Ronde | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove certain portions of this certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the local registrar must be notified of cause.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | Film #G626 - Item #7a. DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 7 0 7 6 3 1 REG. NO. | |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ALICE S. MILLS | | | 2a. DATE OF DEATH MONTH DAY YEAR
03 28 87 | | 2b. HOUR
10:20 P.M. |
| 3 SEX
FEMALE | 4 RACE
BLACK | 5. DATE OF BIRTH MONTH DAY YEAR
09 15 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
93 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CUSTODIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
GOVT. FEDERAL |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE
MARYLAND | | 13c. COUNTY | 13d. CITY OR TOWN
BALTIMORE | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
THOMAS HEBBONS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELIZA LYNN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO. | | 16b. SOCIAL SECURITY NO.
217-26-0352 | | 17. INFORMANT MRS. BALTIMORE, MD. 21216
ELAINE HASSELL 2327 HARLEM AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTION + EDEMA, LUNGS, ACUTE
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL INFARCTION, LEFT FRONTO-PARIETAL
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
RENAL CALCULUS, LEFT RIGHT | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael E Pelczar | | DEGREE
MD | | 22c. DATE SIGNED
3/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL E PELCZAR MD. | | 22e. ADDRESS
900 CATON AVE. BALTO., MD. 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
4/02/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PK. | |
| 23d. LOCATION CITY OR TOWN
BALTIMORE | | COUNTY
BALTIMORE | | STATE
MD. | |
| 24. FUNERAL DIRECTOR'S NAME
NUNER + SON'S FUNERAL HOME, INC. | | ADDRESS
2501 GWYNNS FALLS PKWY, BALTIMORE, MD, 21216 | | 25a. DATE REC'D BY REGISTRAR
MAR 31 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

4884

100 COTTON FIBRE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place this certificate in the box on page 1 and 2 should be placed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Barbara Ann Miskell | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 3, 1987 | | 2b. HOUR
7:45 M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
November 3, 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Of Maryland | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerical | | 12b. KIND OF BUSINESS OR INDUSTRY
Saga Food Corp. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY
A A Co. | | 13c. CITY OR TOWN
Severn | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Roy C. Zimmerman | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen A. Beachly (Living) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
NA | | 17. INFORMANT
(Husband) ADDRESS
Richard F. Miskell Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Metastatic Renal Carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Doices</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Doices</u> | | | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Mar 6, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>R. H. Hopkins</u>
Singleton Funeral Home Glen Burnie, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 05 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia [Signature]</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>John</i> <i>Miszczuk</i> <i>Miszczuk</i> | | | | | 7a. DATE OF DEATH MONTH DAY YEAR
<i>3</i> <i>28</i> <i>87</i> | | 2b. HOUR
<i>11:15 PM</i> | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>12</i> <i>09</i> <i>17</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>69</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>City</i> <i>Balto. City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Beth. Steel</i> | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>3134 Foster Avenue 21224</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Michael</i> <i>Miszczuk</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Mary</i> <i>Laszcak</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>W.W. 2</i> | | 17. INFORMANT ADDRESS
<i>Anna J. Oliaccio 1317 Dundalk Ave. 21222</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable Metastatic Cancer - Unknown</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Liver disease</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Liver disease</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>3/19</i> <i>87</i> <i>3/28</i> <i>87</i>
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/19</i> <i>87</i> to <i>3/28</i> <i>87</i> , that (I) (we) lost <i>3/28</i> <i>87</i> above, (I) (we) (did) (did not) view the body after death. <i>19</i> <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE
<i>E. Dubin</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>3/29</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Dubin</i> | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>4-1-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Holy Rosary</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Dundalk, Balto. Co., Md.</i> | | |
| 24. FUNERAL DIRECTOR NAME
<i>Charles S. Zeiler & Son Inc.</i> | | | | | ADDRESS
<i>6224 Eastern Ave.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 31 1987</i> | | |
| | | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN O. MITCHELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 1, 1987 | | | 2b. HOUR P
3:50 M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2-21-1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Boeing Public Affairs | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY
AA Co. | | 13c. CITY OR TOWN
Churchton | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
5751 Blaine Rd. 20733 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John H. Mitchell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Ruth Loyd | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
WW11 | | 17. INFORMANT
Elizabeth L. Mitchell | | | | |
| 16c. ADDRESS
Same as #13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>hepatic failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>alcoholic cirrhosis</u>
Approximate interval between onset and death:
<u>minutes</u>
<u>months</u>
<u>years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> 19 <u>87</u> , to <u>3/1</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>S Koven</u> | | | DEGREE
<u>MD</u> | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3/1/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Suzanne Koven</u> | | | 22e. ADDRESS
<u>Johns Hopkins Hospital</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Cremation</u> | | | 23b. DATE
<u>3-3-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Westview Crematory</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore Balt. Md.</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Hardesty Funeral Home Annapolis</u> | | | ADDRESS
<u>Md.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 03 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Richard R. Rouse</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

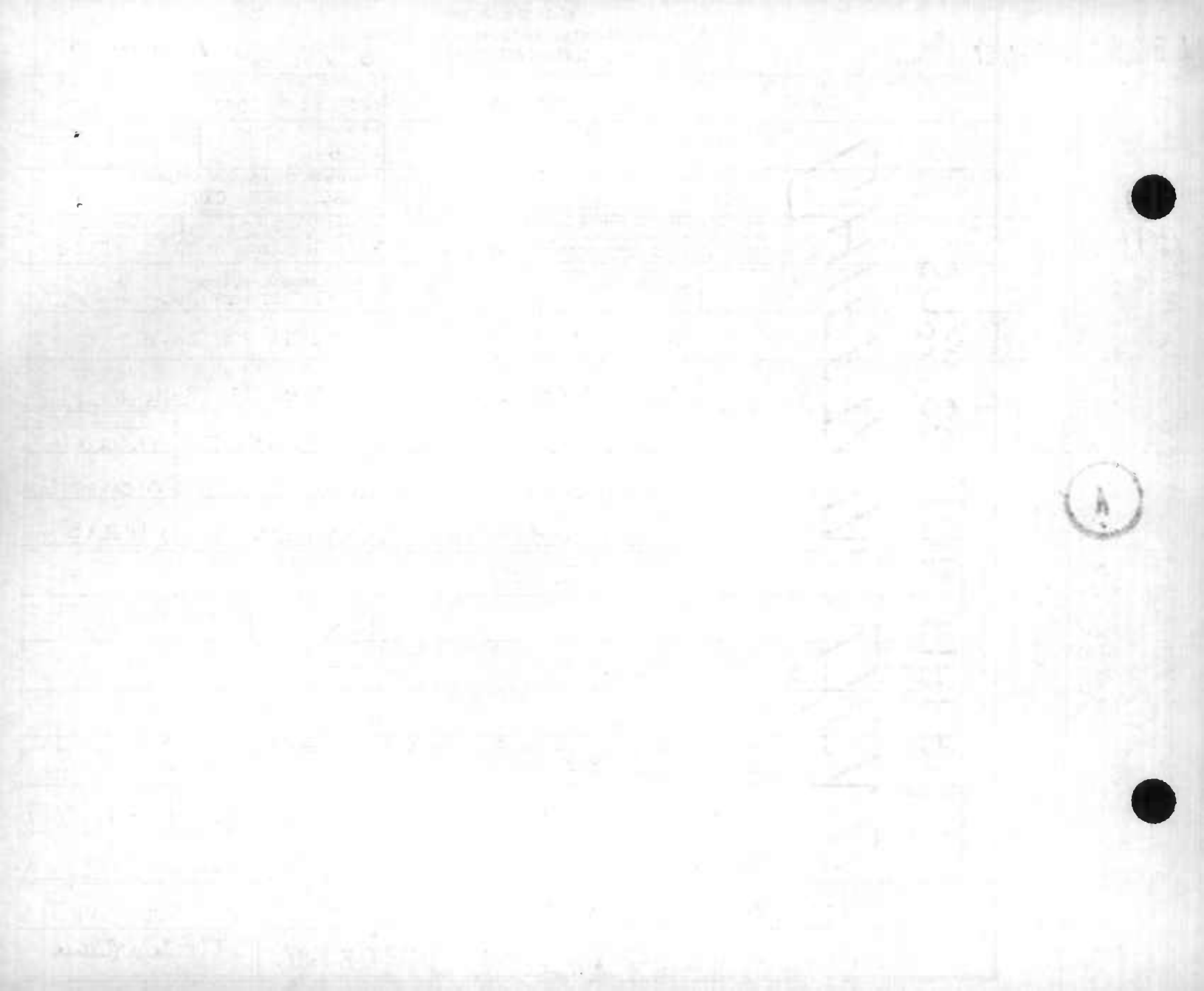
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital as attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

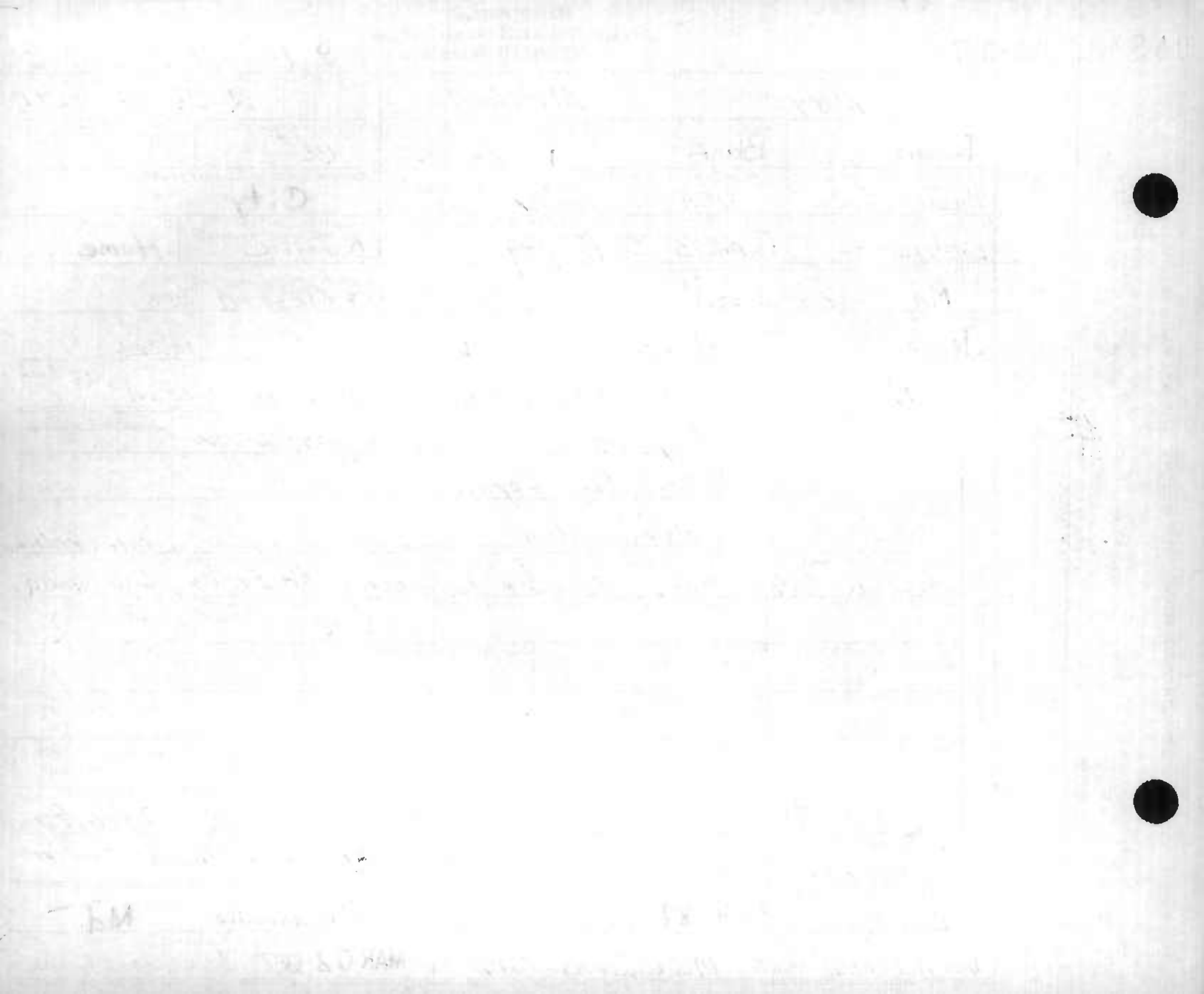
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked correct, 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07635

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>Mary Mitchell</i> | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>2 26 87</i> | | 2b. HOUR
<i>9:27 P</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>1 24 1922</i> | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<i>65</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Chester, S.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>City</i> | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Domestic</i> | |
| 12b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | | | | | |
| 13a. STATE
<i>Md</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>104 Chestnut St. 21222</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Jesse Hicks</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Eva Hicks</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>219-22-4629</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Vivian Thomas 104 Chestnut St 21222</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Hypoxia, Acidosis, Hypotension</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
<i>Status Epilepticus</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Bullous Emphysema, Possible Pulmonary Embolus, Lymphoma</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Loys</i> | | DEGREE | | 22c. DATE SIGNED
<i>2/26/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Charles W. HOGE</i> | | 22e. ADDRESS
<i>90 Francis Scott Key Medical Center</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>3-4-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Crownsville</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Crownsville Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME
<i>Mrs. A. Morton + Sons</i> | | ADDRESS
<i>1701 Laurens St.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 02 1987</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Julia Seiden-Rudner</i> | | | | | |



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the Registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07636 | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<u>MAURICE MITCHELL</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>3 19 87</u> | | | |
| 3. SEX
<u>F</u> | | 4. RACE
<u>B</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>8 10 80</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>86</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>SC</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>BALTIMORE CITY</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF ANY IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>833 GEORGE ST</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Rememoran at Home</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<u>MD</u> | | 13b. COUNTY
<u>Baltimore</u> | | 13c. STREET ADDRESS / ZIP CODE
<u>833 George St</u> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<u>Her Fountain</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Norris 21291</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>no</u> | | 16b. SOCIAL SECURITY NO.
<u>248-62-2048</u> | |
| 17. INFORMANT ADDRESS
<u>Mary McBride 833 George St</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Diabetes Mellitus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>cardiac Arrhythmia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 yrs</u>
<u>10 yrs</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>H/o Peripheral Vascular Disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>10</u> 19 <u>79</u> , to <u>3</u> 19 <u>87</u> , that (we) lost saw the deceased alive on <u>8/4</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>John E. Stodolski M.D.</u> | | DEGREE
<u>M.D.</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3/19/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>John E. Stodolski</u> | | 22e. ADDRESS
<u>1701 W. Pratt ST</u> | | CITY OR TOWN
<u>Baltimore</u> | | COUNTY
<u>MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Removal</u> | | 23b. DATE
<u>3/2/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Buried at Harpersville SC</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
<u>Maryanne D. Hayes</u> | | ADDRESS
<u>638 N. E. Lamar St</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 20 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John Stodolski</u> | |



COPIED



2

049-35 APR-1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please move the certificate to page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--------------------------|--|---|--|---------------------------------------|---|---|--|
| FOR STATE REGISTRAR | | | | | | | | | | |
| REG. NO. 07631 | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ZEBBY MITCHELL | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 3-27-87 | | 2b. HOUR
11-12 PM | | | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR 1-22-41 | | 6. AGE
(IN YEARS, LAST BIRTHDAY) 45 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) Hampstead NC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. city MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) Furn Meade | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST James Mitchell | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Magdalene Hardison | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS Mary V. Mitchell 2305 W. Master St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CardioPulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Dilated Cardio myopathies
DUE TO, OR AS A CONSEQUENCE OF
(c) Massive MI or pulmonary Embolism
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Cerebrovascular Accident. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-27-87 to 3-27-87 , that (I) (we) lost
saw the deceased alive on 3-27-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Darshan S. Saluja | | | | DEGREE | | 22c. DATE SIGNED
3-28-87 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DARSHAN S. SALUJA | | | | 22e. ADDRESS
600 MT Royal Ave, Balto 21217 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
4-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville VA. Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville | | | | |
| 24. FUNERAL DIRECTOR
NAME Brown-Thompson ADDRESS 1913 W. Balto St. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 1 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Swinton | | | | |

BP

1

Page 10 of 10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. CERTIFICATES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS CERTIFICATE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|---------|--|--|--|--|---|--|--|--|--|---|--|--|--|--|-------------------------------------|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--------------------------|--|--|--|--|---|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Item #18a., & 22a., & 22b. G
FOR
1- STATE Med. Ex., 3/26/87
REGISTRAR Gbj | | | | | | | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07632 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | 20. DATE KNOWN OF DEATH | | | | | | | | | | | | | | | 21. DATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WILLIAM F. MOEBIUS | | | | | | | | | | | | | | | 3 13 19 87 | | | | | | | | | | | | | | | 3 13 19 87 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. SEX | | | | | 3. RACE | | | | | 4. DATE OF BIRTH | | | | | 5. AGE (IN YEARS LAST BIRTHDAY) | | | | | 6. IF UNDER 1 YR. | | | | | 7. IF UNDER 24 HRS. | | | | | 8. DATE PRONOUNCED DEAD | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male | | | | | White | | | | | April 1 1939 | | | | | 47 YRS. | | | | | | | | | | | | | | | 3 13 19 87 | | | | | 4:50 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 11. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 12. MARRIED | | | | | | | | | | 13. NEVER MARRIED | | | | | | | | | | 14. WIDOWED | | | | | | | | | | 15. DIVORCED | | | | | | | | | | 16. BALTIMORE CITY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Md. | | | | | | | | | | U.S.A. | | | | | | | | | | <input checked="" type="checkbox"/> | | | | | | | | | | <input type="checkbox"/> | | | | | | | | | | <input type="checkbox"/> | | | | | | | | | | <input type="checkbox"/> | | | | | | | | | | Baltimore City | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. CITY OR TOWN OF DEATH | | | | | | | | | | | | | | | 18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | | | | 19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | | | | | | 20. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Baltimore | | | | | | | | | | | | | | | 512 Luzerne Ave. | | | | | | | | | | | | | | | Firefighter | | | | | | | | | | | | | | | Balto. City | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | 22. STATE | | | | | | | | | | | | | | | 23. COUNTY | | | | | | | | | | | | | | | 24. CITY OR TOWN | | | | | | | | | | | | | | | 25. INSIDE CITY LIMITS? | | | | | | | | | | | | | | | 26. STREET ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Md. | | | | | | | | | | | | | | | - | | | | | | | | | | | | | | | Baltimore | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | 512 N. Luzerne Ave. 21205 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. FATHER'S NAME | | | | | | | | | | | | | | | 28. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | 29. INFORMANT | | | | | | | | | | | | | | | 30. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| William C. Moebius | | | | | | | | | | | | | | | Marguerite E. Surguy | | | | | | | | | | | | | | | Dorothea Moebius (wife) | | | | | | | | | | | | | | | 2453 Fairway 21222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | | | | | | 32. SOCIAL SECURITY NO. | | | | | | | | | | | | | | | 33. INFORMANT | | | | | | | | | | | | | | | 34. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| yes | | | | | | | | | | | | | | | Peacetime | | | | | | | | | | | | | | | 216-36-0561 | | | | | | | | | | | | | | | Dorothea Moebius (wife) | | | | | | | | | | | | | | | 2453 Fairway 21222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 35. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | 36. PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | 37. IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | 38. CHRONIC ETHANOLISM | | | | | | | | | | | | | | | 39. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (b) | | | | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 40. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 41. DATE OF OPERATION | | | | | | | | | | | | | | | 42. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | 43. AUTOPSY? | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 44. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | | | | | 45. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | 46. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 47. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | 48. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | | | | | | 49. LOCATION | | | | | | | | | | | | | | | CITY OR TOWN | | | | | | | | | | | | | | | COUNTY | | | | | | | | | | | | | | | STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 50. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 51. ACTUAL SIGNATURE | | | | | | | | | | | | | | | 52. TITLE (SPECIFY) | | | | | | | | | | | | | | | 53. MEDICAL EXAMINER | | | | | | | | | | | | | | | 54. DATE SIGNED | | | | | | | | | | | | | | | 3-14-87 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 55. EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | 56. ADDRESS | | | | | | | | | | | | | | | 57. CITY OR TOWN | | | | | | | | | | | | | | | 58. COUNTY | | | | | | | | | | | | | | | 59. STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| William M. Zane, M.D. | | | | | | | | | | | | | | | 111 Penn St., Balto., MD | | | | | | | | | | | | | | | 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 60. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | | | | | | 61. DATE | | | | | | | | | | | | | | | 62. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | | | | 63. LOCATION | | | | | | | | | | | | | | | CITY OR TOWN | | | | | | | | | | | | | | | COUNTY | | | | | | | | | | | | | | | STATE | | | | | | | | | | | | | | |
| BURIAL | | | | | | | | | | | | | | | 3/18/87 | | | | | | | | | | | | | | | MEADOWRIDGE MEM. PARK | | | | | | | | | | | | | | | Baltimore | | | | | | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 64. FUNERAL DIRECTOR'S NAME | | | | | | | | | | | | | | | 65. ADDRESS | | | | | | | | | | | | | | | 66. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | | | | 67. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Schimunek Funeral Home, Inc. | | | | | | | | | | | | | | | 3331 Brehms Lane, Balto. Md. 21213 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MAR 17 1987

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RECEIVED

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 07 040
REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Andrew (Andrei) Monariu | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 24, 1987 | | 2b. HOUR
2:30 P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 1 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5109 Fait Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | |
| 13a. STATE
Md | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Monariu | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
? | | 13e. STREET ADDRESS / ZIP CODE
5109 Fait Avenue 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-07-0900 | | 17. INFORMANT
ADDRESS
Margaret R. Monariu 5109 Fait Ave. 21224 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Squamous Cell Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert B. Geller | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT B. GELLER, MD | | | | 22e. ADDRESS
JOHN H. MOORE'S Oncology Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-27-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Eastwood, Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. | | | | ADDRESS
6224 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

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THE UNIVERSITY OF CHICAGO
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

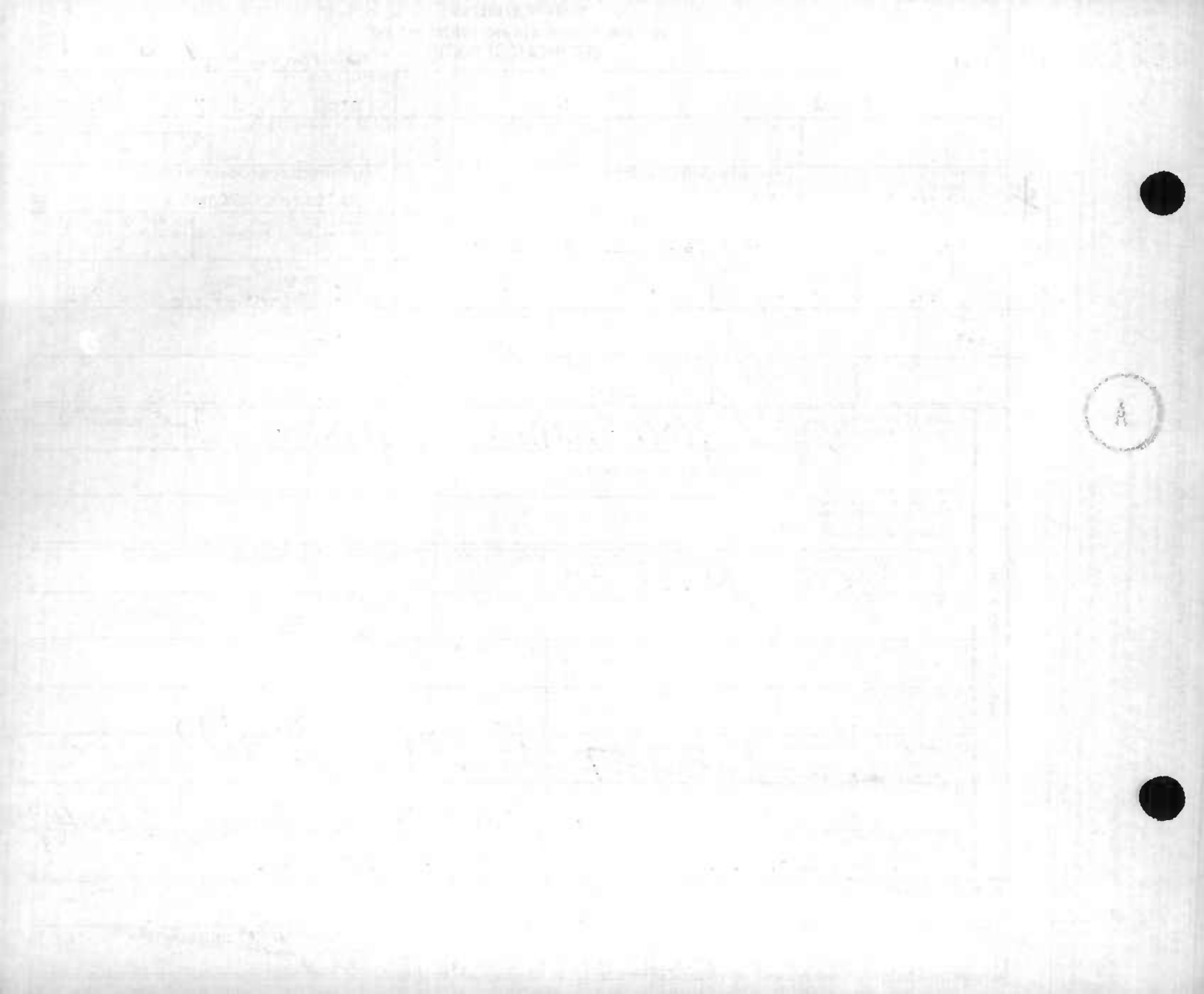
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07641

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ethel Louise Mongo | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 24, 1987 | | 2b. HOUR
4:30P M |
| 3 SEX
Female | 4 RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 16 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Plymouth N.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
- | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willie Wills | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
George Anna Bateman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | 17. INFORMANT ADDRESS
Ulysses Wills 2703 Woodland Ave. 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
DIABETES MELLITUS | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/12/87 to 3/24/87, that (I) (we) lost the deceased alive on 3/12/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Ian Sunshine, M.D. | | DEGREE
MD | | 22c. DATE SIGNED
3/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ian Sunshine, M.D. | | 22e. ADDRESS
6210 Park Heights Ave. | | 358-1555 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/30/87 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glenn Burnie, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H West 4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | | |



048941 APR -17

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07642 | |
|---|--|---|--|---|--|--|--|--|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARGARET W MOONEY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-29-87 | | | 2b. HOUR
1:19 am | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 24, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penn. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital, Balto. Md | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales manager, Mitchill, Bake | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Baltimore | | | | 13b. COUNTY
----- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
21223
2668 Dulaney St. Balto. Md. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
198-12-1462 | | 17. INFORMANT ADDRESS
Mr. George W. Klebe, Sr. 1303 Marshall St. Balto. Md. 21230 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
15 min | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Pancreatic Carcinomatosis | | | | | | | | | | 1 MO. | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) + | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 4 , 19 87 , to MAR 29 , 19 87 , that (I) (we) last saw the deceased alive on MAR 29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Anthony Pignataro | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Anthony Pignataro | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
4/1/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemt. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McCully Funeral Home, 130 E. Fort Ave. | | | | | | 25a. DATED BY REGISTRAR'S SIGNATURE
MAR 30 1987 | | | | | |

10-25-5

10-25-5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove white labels and papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07643
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOUR MIN. | |
| FIRST MARY | | 3 14 87 | | 825 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| F | | W | | MONTH DAY YEAR | |
| | | | | 3 16 1914 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Maryland | | USA | | 72 YRS | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | | St. Agnes Hospital | | Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Homemaker | | --- | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS / ZIP CODE | |
| 13a. STATE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 808 Unetta Avenue, 21229 | |
| Maryland | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Patrick Fitzpatrick | | Dora Barrett | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 212-10-4738 | | Patrick M. Mooney, 5219 Larlin Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | WEEKS | | | |
| IMMEDIATE CAUSE (a) ANOXIC ENCEPHALOPATHY | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) EXTENSIVE ACUTE MYOCARDIAL INFARCT | | WEEKS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/16, 19 87, to 3/14, 19 87, that (we) lost saw the deceased alive on 3/14/87, 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Steven H. Pearlman | | | | 3/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| STEVEN H. PEARLMAN | | ST. AGNES HOSPITAL 500 S. CARON AVE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3/18/87 | | New Cathedral Cem. | |
| | | | | 23d. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| | | | | Baltimore Maryland | |
| 24. FUNERAL DIRECTOR | | 25. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS | | 25. REGISTRAR'S SIGNATURE | | | |
| Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | MAR 16 1987 | | | |

MEDICAL CERTIFICATION

DHMH - 16 60M 7/84
(VRA 15, 4)

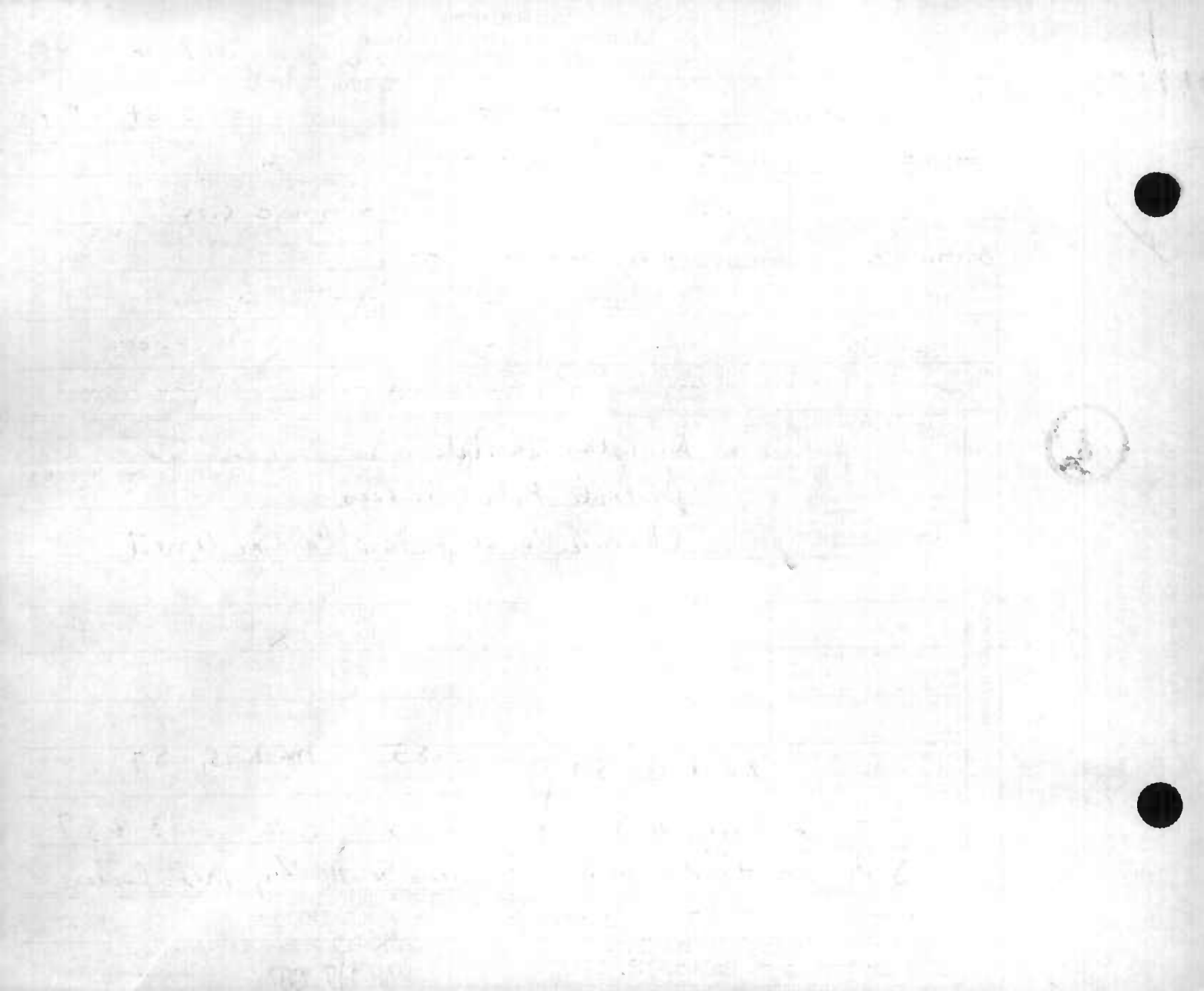
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 87 07645
REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR | |
| Doilie | | MAE | | MOORE | | | | 3 15 87 | | 140 P.M. | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 74 HRS
HOURS MIN. | |
| female | | white | | Oct. 13 1952 | | 34 YRS. | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Francis Scott Key Medical Center | | | | | | Homemaker | | - | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Md. | | - | | Baltimore | | | | 1201 Quantril Way 21205 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| Sherwood | | Rabon | | Bessie | | Griffin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | | | |
| no | | 212-58-6092 | | Jessie Moore Jr. (husband) same address | | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Ketoacidosis</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal Failure, Cardiac Arrest</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>85</u> to <u>March 15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | |
| 22b. SIGNATURE <u>J.B. Zachary, M.D.</u> | | | | | | | | | | 3-16-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>J.B. ZACHARY, M.D.</u> | | | | | | | | | | 22e. ADDRESS
<u>Francis Scott Key Med. Center</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| Cremation | | 3/17/87 | | Greenmount | | Baltimore | | Md. | | | |
| 24. FUNERAL HOME, INC.
<u>Schumanek Funeral Home, Inc.</u>
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | MAR 17 1987 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07646
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|--|---|---|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Ellis P. Moore | | | 2a DATE OF DEATH
MONTH DAY YEAR
March 19, 1987 | | | 2b HOUR
M
M | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 5, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
1422 Marshall St. Balto. Maryland | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b KIND OF BUSINESS OR INDUSTRY
Globe Brewing | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Louis --- Moore | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella --- Thomas | | | 13e STREET ADDRESS / ZIP CODE
1422 Marshall St. Balto. Md. 21230 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-01-0797 | | 17 INFORMANT
ADDRESS
Mrs. Margaret Moore, Same as above | | | | |

| | | |
|---|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic Myocardial Degeneration</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic Obstructive Pulmonary Disease</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>5 yr.</u>
<u>5 yr.</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | |

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>75</u> , to <u>3-19</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3-18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
<u>A. S. Tolled</u> | | | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>3-20-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | |

| | | | | | | | |
|--|--|-------------------------|--|---|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/21/ 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
BALTO. MARYLAND COUNTY A.A.Co. STATE | |
| 24 FUNERAL DIRECTOR
McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 7 and 8, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07641

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Marshall | | FIRST
J. | | MIDDLE
Moore | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 10 87 | | 2b. HOUR
M | |
| 3 SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 10 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oxford, N. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Residence | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Haas Tailoring | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8 S. Bernice Ave. 21229 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Moore | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Bullock | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | 16b. SOCIAL SECURITY NO.
218-10-2705 | | 17. INFORMANT
ADDRESS
Ella M. Moore 8 S. Bernice St. 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST, CHF</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PERICARDIAL DISEASE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>ISCHEMIC HEART DISEASE</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>2/27/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Anil Tinterpartic</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>CANYONICK 21228</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ANIL TINTERPARTIC</u> | | 22e. ADDRESS
<u>720 MAIDEN ROCK RD</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W.C. March E/H West 4300 Wabash Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Tindler-Rodack</u> | | | |

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1000 1000 1000



1000 1000 1000



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 07648
REG. NO.

| | | | | | | |
|--|--|--|--|--|----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Sam Moran | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-25-87 | | 2b. HOUR
5 ³⁰ P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-1-1898 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
28 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LEVINDALE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman WHOLESALE MEATS | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BENJAMIN MORAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CHAVA RACHEL MEMEROVSKY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
265-62 5369 | | 17. INFORMANT
MRS. PHYLLIS FRANZ
6716 CHIPPEWA DR. 21209 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION.
DUE TO, OR AS A CONSEQUENCE OF (b) ANEURYSM WITH ATRIAL FIBRILLATION.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-4-1987 to 3-25-1987, that (I) (we) lost
saw the deceased alive on 3-25-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (do) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
M.D. | | 22c. DATE SIGNED
3/25/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SET HTAWAR | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MAR. 27, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH EL MEM. PARK | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
RANDALLSTOWN BALTO. MD | | 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, be sure to complete and sign the line (only be completed another

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07649 | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
BORD W MORRIS, Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 1 87 | | 2b. HOUR
7 35 PM |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH MONTH DAY YEAR
3 11 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Postal Office | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mannie Gray | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-09-4314 | | 17. INFORMANT ADDRESS
Elaine T. Morris 4009 Barrington Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) PROSTATE CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27, 19 87, to 3/1, 19 87, that (I) (we) last saw the deceased alive on 3/1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
S. B. Miller MD | | DEGREE
MD | | 22c. DATE SIGNED
3/1/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SAMUEL B MILLER | | 22e. ADDRESS
SINAI HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Arbutus, Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS
Wm C March F/H West 4300 Wabash Ave. | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 04 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |

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NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | | | 4. RACE | | | |
| DELORES MAY MORRIS | | FEMALE | | | | BLACK | | | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS, LAST BIRTHDAY) | | | | 7. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| 8/23/41 | | 44 YRS. | | | | Baltimore City MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Maryland | | USA | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12c. STREET ADDRESS, ZIP CODE | | | |
| Baltimore | | J.H. DEATON MED. CENTER + HOSP | | | | 4902 Challedon Rd. 21215 | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS, ZIP CODE | |
| Maryland | | | | Baltimore | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Vernon | | Gladys | | No | | 219-40-7270 | | Walter S. Morris (same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Septic 2° Cellulitis rt upper arm</u> | | | | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF (b) <u>S/P Cardiorespiratory Arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coma 2 "b"</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4 March 1987</u> to <u>28 March 1987</u> , that (I) (we) lost saw the deceased alive on <u>28 March 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| J.W. Reed M.D. | | | | | | 3/30/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| J.W. REED, M.D. | | 611 S. CHAS. ST. BALTA MD 21208 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 4/2/87 | | Cedar Hill Cem. | | Glenn Burnie Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE OF DEATH BY REGISTRATION | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H 4300 Wabash Ave. | | APR - 2 1987 | | | | Julia Dikson-Randner | | | |

4/9



048777 MAR 1987

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. IF THE MEDICAL EXAMINER ALREADY HAS A FORM, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALBANY STREET, BALTIMORE, MD. 21201. IF THE MEDICAL EXAMINER HAS NO FORM, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALBANY STREET, BALTIMORE, MD. 21201. IF THE MEDICAL EXAMINER HAS NO FORM, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALBANY STREET, BALTIMORE, MD. 21201. IF THE MEDICAL EXAMINER HAS NO FORM, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALBANY STREET, BALTIMORE, MD. 21201.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 07651 |
|---|-------------------------|---|--|--|-----------------------------------|---|--|---|--------------------------|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES Benton MORRISON | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
3-28-87 |
| 1. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
3 24 87 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
4 | IF UNDER 1 YR
IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3-28-87 | | 2d. HOUR
8:32A | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Dependent | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
107 Deepdene Rd. 21210 | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alfred J. Morrison | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine J. Jones | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Mr. Alfred J. Morrison same as 13e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interventricular septal defect of the heart
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
3-29-87 | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/30/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | | | 23d. LOCATION
Balto. Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR
Ruck Towson Funeral Home, Inc. | | | | 24b. ADDRESS
1050 York Rd. | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon of pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be called and a medical examination must be performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 87 07052 | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Floyd (Musley) | | | | 2a. DATE OF DEATH MONTH DAY YEAR March 22 1987 | | | |
| 3 SEX M | | | | 2b. HOUR 2:00 AM | | | |
| 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 5 2 32 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH, Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Med. Center | | 12a. USUAL OCCUPATION (17a. WORK FOR MOST OF WORKING LIFE) DISAB. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. CITY OR TOWN Baltimore | | 13c. STREET ADDRESS / ZIP CODE 1402 E. Lanvale St. 21213 | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Tennessee Mosley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Blanton | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 214264924 | | 17. INFORMANT ADDRESS Joan Mosley 1402 E. Lanvale St. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatitis
DUE TO, OR AS A CONSEQUENCE OF (b) Alcohol Abuse
DUE TO, OR AS A CONSEQUENCE OF (c) 10 years
30 years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Ischemic Heart Disease; Dementia; Tuberculosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 20 March 1987 to 22 March 1987 that (I) (we) last saw the deceased alive on 20 March 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE David A. Jung | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3/22/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Jung | | 22e. ADDRESS Liberty Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | 23b. DATE 3/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel MD | |
| 24. FUNERAL DIRECTOR NAME March Funeral Home | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE John Davidson | |



046323 MAR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to interment, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE H. MOULTHROP | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR
3 3 87 1:10pm
M | | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 17 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | | 7b. HOUR
1:10pm
M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CANADA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RET./MGR. | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | |
| 13a. STATE
Maryland | | | | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
309 WESTOWNE ROAD 21229 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Allison Moulthrop | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie B. Arnold | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | 16b. SOCIAL SECURITY NO.
083-03-5494 | | 17. INFORMANT
Mrs. C. Ruth Moulthrop Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal failure, UTI</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Diab. mellitus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
<u>CVA, history of MI, heart block, alzheimer's d.s., decubital ulcer</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-24-87</u> , 19 <u>87</u> , to <u>3-3-87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3-3-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Scaypore</u> | | | | | DEGREE | | 22c. DATE SIGNED
3-3-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDNA YEO WONG | | | | | 22e. ADDRESS
87 Agnes hosp Baltimore, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/6/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
Leroy M. & Russell C. Witzke
1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 05 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

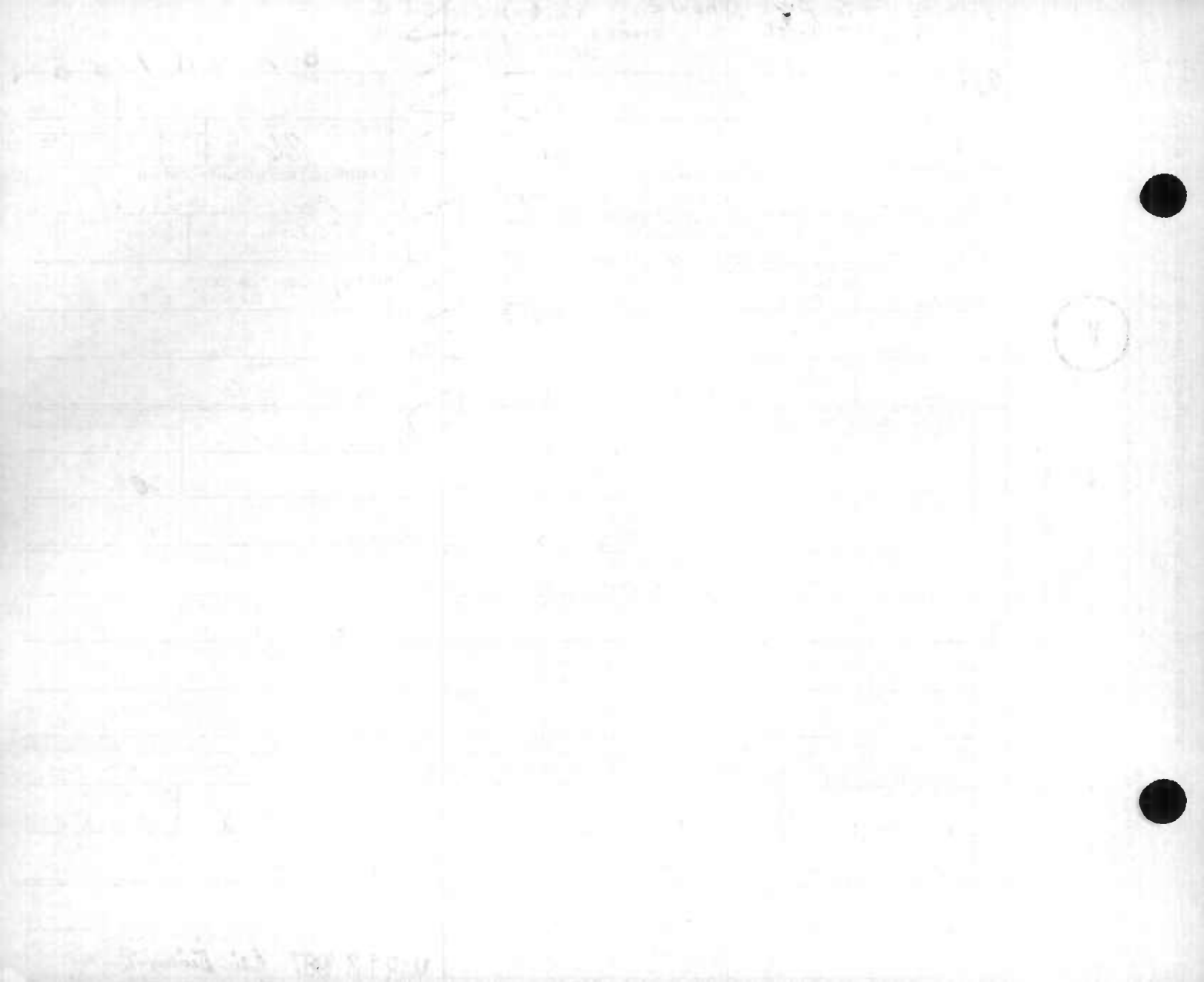
Items 5 + 6 per phone

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07654

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Marie Morie</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 11 87</i> | | | 2b. HOUR
<i>9:20 PM</i> | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>10 01 01</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>86</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY)
<i>N Carolina</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>University of Maryland Hosp</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>0</i> | |
| 13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Balto</i> | | 13c. CITY OR TOWN
<i>Balto</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Unknown</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Unknown</i> | | | 13e. STREET ADDRESS / ZIP CODE
<i>437 Oxford Ct 21201</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>Unknown</i> | | 17. INFORMANT
ADDRESS
<i>myself R Brown MD</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiovascular collapse / Cardiac Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Pulmonary Embolism</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Deep Venous Thrombosis</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 minutes</i>
<i>20 hrs</i>
<i>~ 1 week</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Possible Cerebrovascular accident</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>22 S. Green St Baltimore City Md.</i> | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/10</i> 19 <i>87</i> , to <i>3/11</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>3/11</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Russell D Brown MD</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<i>3/11/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Russell D. Brown MD</i> | | | | | 22e. ADDRESS
<i>22 S. Green St Baltimore</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>3/16/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Eastview Cem</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore City Md.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>W.C. March F/H West 4300 Wabash Ave.</i> | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 13 1987</i> | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | |

BP



047419 MAR 8

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 07655

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM W. MULLINEAUX | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03-16-87 | | 2b. HOUR
11:05 PM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
03 21 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
03 21 22 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Balto. City Police | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired |
| 13a. STATE
MD. | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4931 Schaub Avenue -21206 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter L. Mullineaux | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Dobbs | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | 17. INFORMANT
ADDRESS
Emma P.D. Mullineaux - 4931 Schaub Ave.-21206 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARDIAC ARRHYTHMIA DURING ANESTHESIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>MULTIPLE BRAIN STEM STROKES</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>DIABETES</u> | | | | | |
| 19a. DATE OF OPERATION
<u>03-16-87</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>GASTROSTOMY FEEDING TUBE</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 10, 1987</u> to <u>MARCH 16, 1987</u> , that (I) (we) lost
saw the deceased alive on <u>3-16, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>D. Hooper, M.D.</u> | | | | 22c. DATE SIGNED
<u>3-16-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>D. HOOPER, M.D.</u> | | | | 22e. ADDRESS
<u>GOOD SAMARITAN HOSPITAL BALTIMORE</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>3-19-87</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Balto. Md.-21234</u> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>John C. Miller, Inc.-6415 Belair Road-21206</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 17 1987</u>
25b. REGISTRAR'S SIGNATURE
<u>Julia T. ...</u> | |

MEDICAL CERTIFICATION

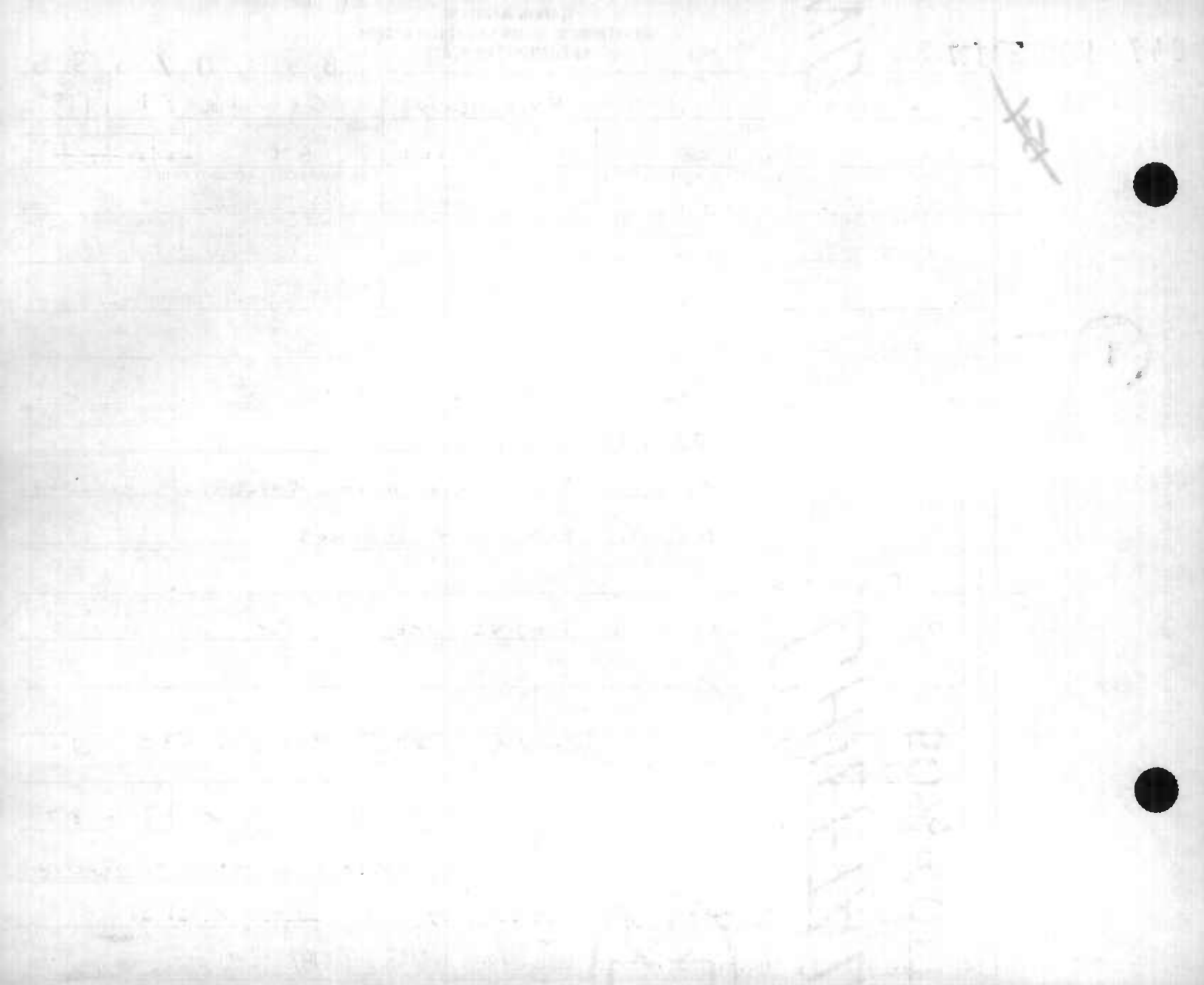
29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



046867 MAR 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REC. NO. 07656

| | | | | | | |
|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
NANCY C. MULLOWNEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 10 87 | | 2b. HOUR
4³⁰ A M | |
| 1. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 16, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
X | IF UNDER 24 HRS.
HOURS MIN.
X |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ORANGE, N.J. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESPERSON | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL SALES | |
| 13a. STATE
MD. | | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
TOWSON | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CARLOS WILLIAM CURTISS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH HALEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-34-2336 | | 17. INFORMANT
ADDRESS
CAROLYN M. JENKINS BALTIMORE, MD 21234 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
~ 3 days | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
N/A | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 2 , 19 87 , to March 10 , 19 87 , that (I) (we) lost
saw the deceased alive on March 10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Karen S. Brown MD | | | | 22c. DATE SIGNED
3-10-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KAREN S. BROWN | | | | 22e. ADDRESS
U. OF MARYLAND HOSPITAL, BALT. MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
MARCH 11, '87 | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM E. JOHNSON | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | |
| ADDRESS
8521 LOCH RAVEN BLVD. | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Pandora | | |

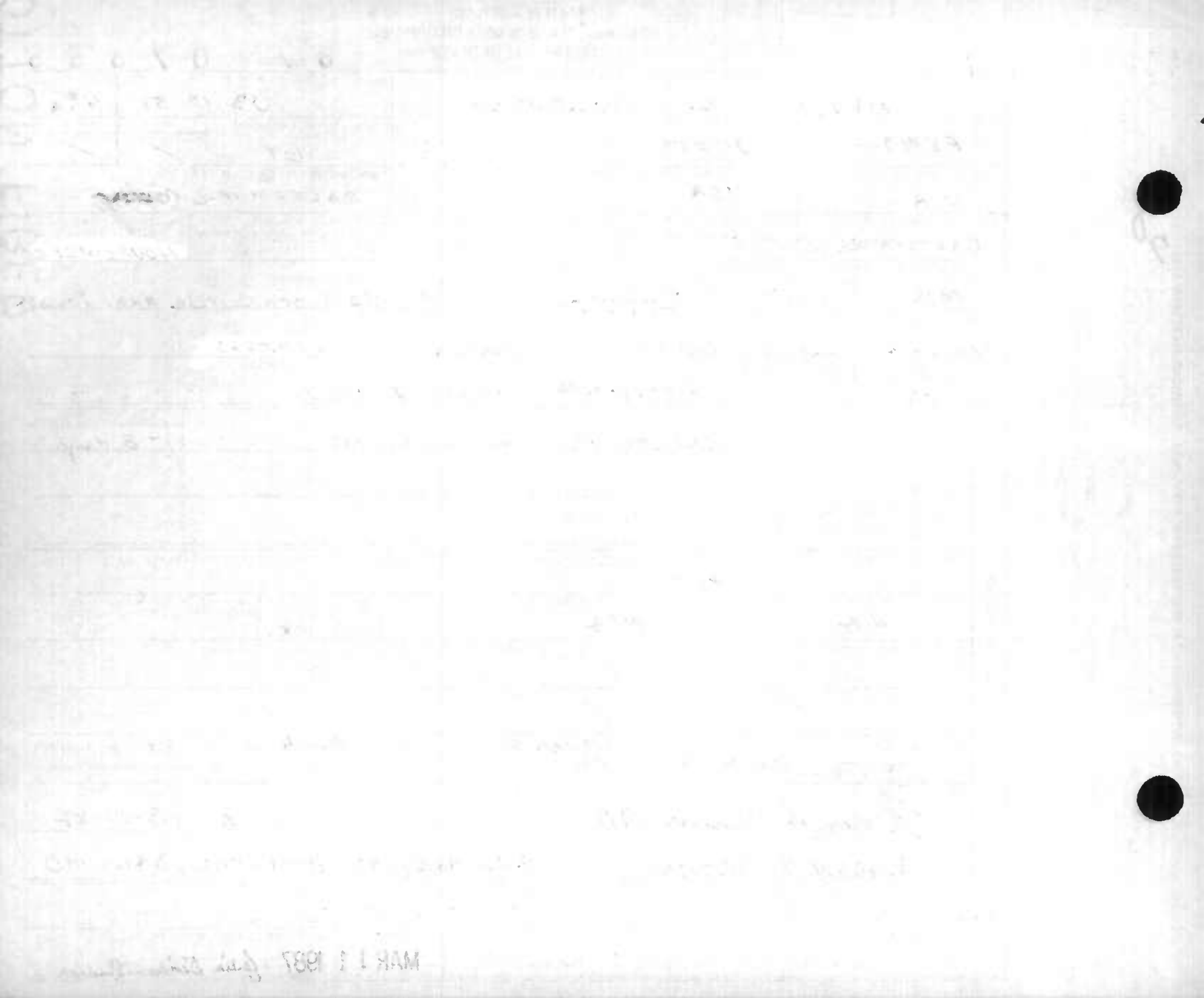
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then, please insert complete papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



#18a, 211-22a., 3/6/87 by **STATE OF MARYLAND**
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **07657**

1- Med. Ex., /Gbj.
 REGISTRAR **G-625**

| | | | | | | | | |
|--|-----------------------------------|--|---|---|------------------|---|------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LAWRENCE B. MUMAW | | | 2a. DATE KNOWN OF DEATH
ESTI- MATED <input checked="" type="checkbox"/> 2-4-87 19 | | | 2b. HOUR M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR 10/14/62 | 6. AGE (IN YEARS)
LAST BIRTHDAY 24 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2-4-87 19 | 7d. HOUR 10:15A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Plumb/Heat |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE
Md | 13b. COUNTY
Balto. City | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3602 Parkdale Avenue 21211 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Kenneth Mumaw | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gwendolyn Music | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218 88 5389 | | 17. INFORMANT
Brenda Mumaw | | ADDRESS
same | | |

| | |
|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Narcotic intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 1 25 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject use drugs | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
unknown | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
unknown Baltimore, - Maryland | |

| | | | | | |
|---|--|-------------------------------------|--|------------------------------|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
2-5-87 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn Street | | | |

| | | | |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
02/07/87 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville, Balto. Co. Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Burgee-Henss Funeral Home 3631 Falls Rd 21211 | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1987 | 25b. REGISTRAR'S SIGNATURE
Julia Dinkon-Randee |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGINS OF PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER OF THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL OF THE REMAINS. THIS FORM MAY BE REPRODUCED FOR YOUR FILES. IF IT IS TO BE USED AS A BURIAL TRANSFER, IT SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL OF THE REMAINS.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

100-100000

RECEIVED
FEB 12 1967



FEB 12 1967
FBI - NEW YORK

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07658

1- FOR
STATE
REGISTRAR

| | | | | |
|--|-------------------------|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Martha Ann Myers | | 2a. DATE KNOWN OF DEATH
XX MONTH DAY YEAR
3-2 1987 | | 2b. HOUR
M
5:30 p. M |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
May 3, 1946 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
40 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 7c. DATE PRONOUNCED DEAD
3-2 1987 | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital - STU | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
secretary |
| 12b. KIND OF BUSINESS OR INDUSTRY
construction | | 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Delaware | | |
| 13b. COUNTY
Sussex | | 13c. CITY OR TOWN
Millsboro | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
62 Oak Drive |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Philip Mitchell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillie H. Cummings | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
219-42-7973 | | 17. INFORMANT ADDRESS
Michael Mitchell Oak Drive, Millsboro, De. |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8147 IMMEDIATE CAUSE (a) Cranio-Cerebral Injury | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | |
| | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10

| | | | | |
|---|--|---|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1:13 PM 3-1 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
pedestrian struck by auto |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
parking lot | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Roland Ave., Salisbury, Wicomico Co., Maryland |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
M.D. Assistant | | DATE SIGNED
3-3-87 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | |

| | | | |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/6/87 | 23c. NAME OF CEMETERY OR CREMATORY
Millsboro Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Millsboro, Sussex C., Del. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Richard T. Watson Millsboro, Del. | | 25a. DATE RECEIVED BY REGISTRAR
MAR 09 1987 | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT SLIP. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

20% COTTON FIBER

DAVID
BROWN
K
H
E
L
L



BP

DHMM - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it can and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It must be filed with the State Dept. of Health and Mental Hygiene prior to burial. (See instructions on reverse.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other infirmity, a medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
KEVIN PATRICK NAGLE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 20, 1987 | | | 2b. HOUR
7:10P M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
July 21, 1980 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
6 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
Maryland | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Ellicott City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10148 Tanfield Ct. 21043 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Dennis Nagle | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Patricia Kiesell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-08-1354 | | 17. INFORMANT ADDRESS
Ellicott City, Md. 21043
Dennis Nagle, 10148 Tanfield Ct. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) WILLIAMS SYNDROME | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min
4 days
6 1/2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 87 to 3/20 19 87 , that (I) (we) last saw the deceased alive on 3/20 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Howard Orel, MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/20/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HOWARD OREL | | | | 22e. ADDRESS
600 N WOLFE ST. BALT, MD 21209 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar. 24, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Bridget's | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Salisbury Herkimer N.Y. | | | |
| 24. FUNERAL DIRECTOR
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Balto., Md. 21214 | | | | | | 25. DATE REC'D BY REGISTRAR
MAR 23 1987 | | | |



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon part 1, page 4, and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07660

| | | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HATTIE B. NANCE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 6 87 | | | 2b. HOUR
12 P.M. | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 3 33 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> SEPARATED
NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PACKER | | 12b. KIND OF BUSINESS OR INDUSTRY
CAR CO. LOWERY GLASS | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4817 Beaufort Ave 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PAM ANDERSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LESSIE FEE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO. | | | 16b. SOCIAL SECURITY NO.
218-30-6015 | | 17. INFORMANT MRS. BALTIMORE, MARYLAND
LESSIE BANKS 4817 BEAUFORT AVE. 21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) COMA
DUE TO, OR AS A CONSEQUENCE OF (c) BRAIN TUMOR | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
mins
1 week
6 months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
GLIOBLASTOMA | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/6 1987 to 3/6 1987 that (I) (we) lost
saw the deceased alive on 3/6 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | |
| 22b. SIGNATURE
Vincent Hall | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/11/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Vincent Hall | | | 22e. ADDRESS
SINAI | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
3/11/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. NATIONAL MEM PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LAUREL, MARYLAND | | | |
| 24. FUNERAL HOME OR NAME
WATERS + SONS FUNERAL HOME, INC. | | | | | ADDRESS
2501 GWYNNS FAULS PKWY, BALTO, MD. 21216 | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
Richard R. Riddick | |

BP

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

~~SECRET~~



100-100000-1000

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-00 BY 100000-1000

0469 08 MAR 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC'D. 7 0 6 1

| | | | | | | | |
|---|---------|--|-------------------|--|---------------------|--|--|
| 1- STATE REGISTRAR | | 20. DATE KNOWN OF DEATH | | 21. DATE OF DEATH | | 22. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | 20. DATE KNOWN OF DEATH | | 21. DATE OF DEATH | | 22. HOUR | |
| Albert Wayne Nash | | 3/ 7/ 19 87 | | 3/ 7/ 19 87 | | 3:44 P M | |
| 2. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | | |
| Male | White | 4-18-1971 | 15 YRS. | 10 | 19 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | WIDOWED | | Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | University Hospital Shock Trauma | | Student | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Maryland | | Frederick | | YES | | 4500 Buffalo Road, 21771 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | |
| Donald Wayne Nash | | Debbie (Unknown) | | No | | None | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. DATE OF OPERATION | | 20. AUTOPSY? | |
| Malone Gouge, Same as # 13 | | Multiple Injuries with Complications | | 3/ 6/ 1987 | | YES | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES | |
| 3/ 6/ 1987 | | Subject bicyclist struck by auto | | YES | | YES | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | |
| UNDERLYING | | 6:30 P.M. 3/ 6/ 1987 | | Subject bicyclist struck by auto | | WHILE AT WORK | |
| 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. DATE REC'D. BY REGISTRAR | | 21h. REGISTRAR'S SIGNATURE | |
| roadway | | Sams Creek Rd. & Buffalo Rd., Carroll Co., Md. | | 3/8/87 | | Charles W. Burrier, Jr., Sykesville, Md. | |
| 22a. I certify that I took charge of the remains described above, held on | | 22b. DATE | | 22c. NAME OF CEMETERY | | 22d. LOCATION | |
| death resulted from | | 3-10-1987 | | Calvary Baptist Ch. | | Mt. Airy, Frederick, Md. | |
| 22e. DATE REC'D. BY REGISTRAR | | 22f. REGISTRAR'S SIGNATURE | | 22g. NAME | | 22h. ADDRESS | |
| 3/8/87 | | Charles W. Burrier, Jr., Sykesville, Md. | | Charles W. Burrier, Jr., Sykesville, Md. | | Charles W. Burrier, Jr., Sykesville, Md. | |

07/84
25M
BP
DHMH - 17
(VR A15 ME (5))

MEDICAL CERTIFICATION

7 8136

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. LEAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

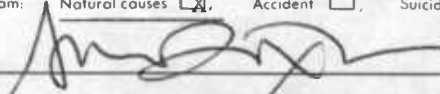
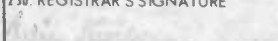
MAR 11 1987

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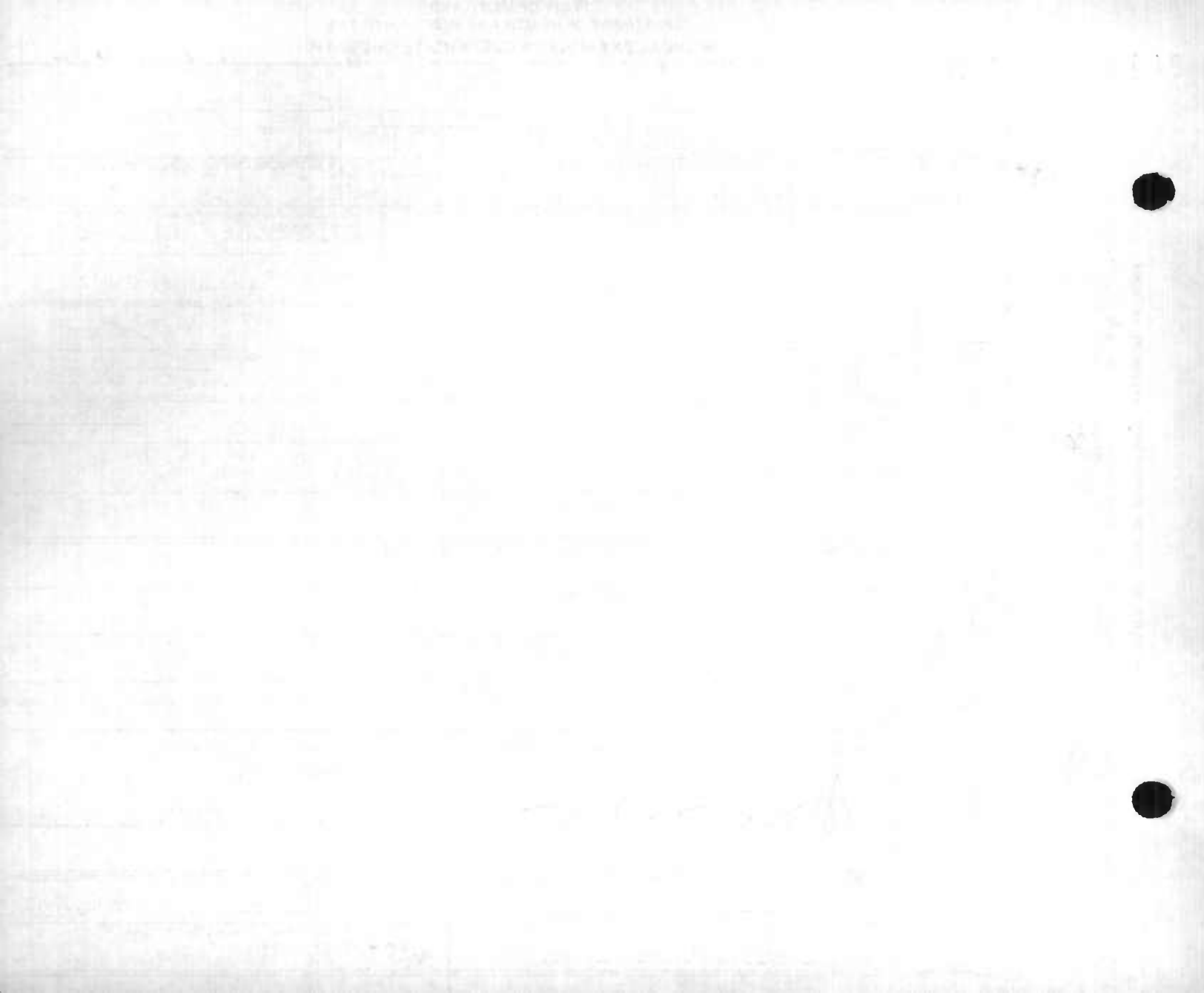
047282 MAR 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT RECEIPT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REC. NO. 7062 | |
|--|---------|---------------------------------|--|---|------------------------------|--|--------------------------------------|---|--|-----------------------------------|--|---|-----------------|
| 1- STATE REGISTRAR | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH | 2b. HOUR |
| 1. DECEASED NAME FIRST MIDDLE LAST
SUSIE J. NASH | | | | | | | | | | | | DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3 1 19 87 | 2b. HOUR M 4:40 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Female | Black | 5 22 1912 | 74 YRS. | Maryland | U.S.A. | | Baltimore City | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | Union Memorial Hospital | | | | Retired Cook | | Baltimore City | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | | Baltimore | | | | 1374 N. Calhoun St. 21217 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Charles Johnson | | | | | | Susie Jackson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | | 216-12-0302 | | Thomas A. Adams 1819 N. Payson St. 21217 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Congestive heart failure | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER | | | | | | | | | | | | DATE SIGNED 3-2-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | | | | | | | ADDRESS 111 Penn St., Balto., MD 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 3-6-87 | | Baltimore National | | | | Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Bailey Funeral Home 1348 N. Calhoun St. 21217 | | | | | | MAR 13 1987 | |  | | | | | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

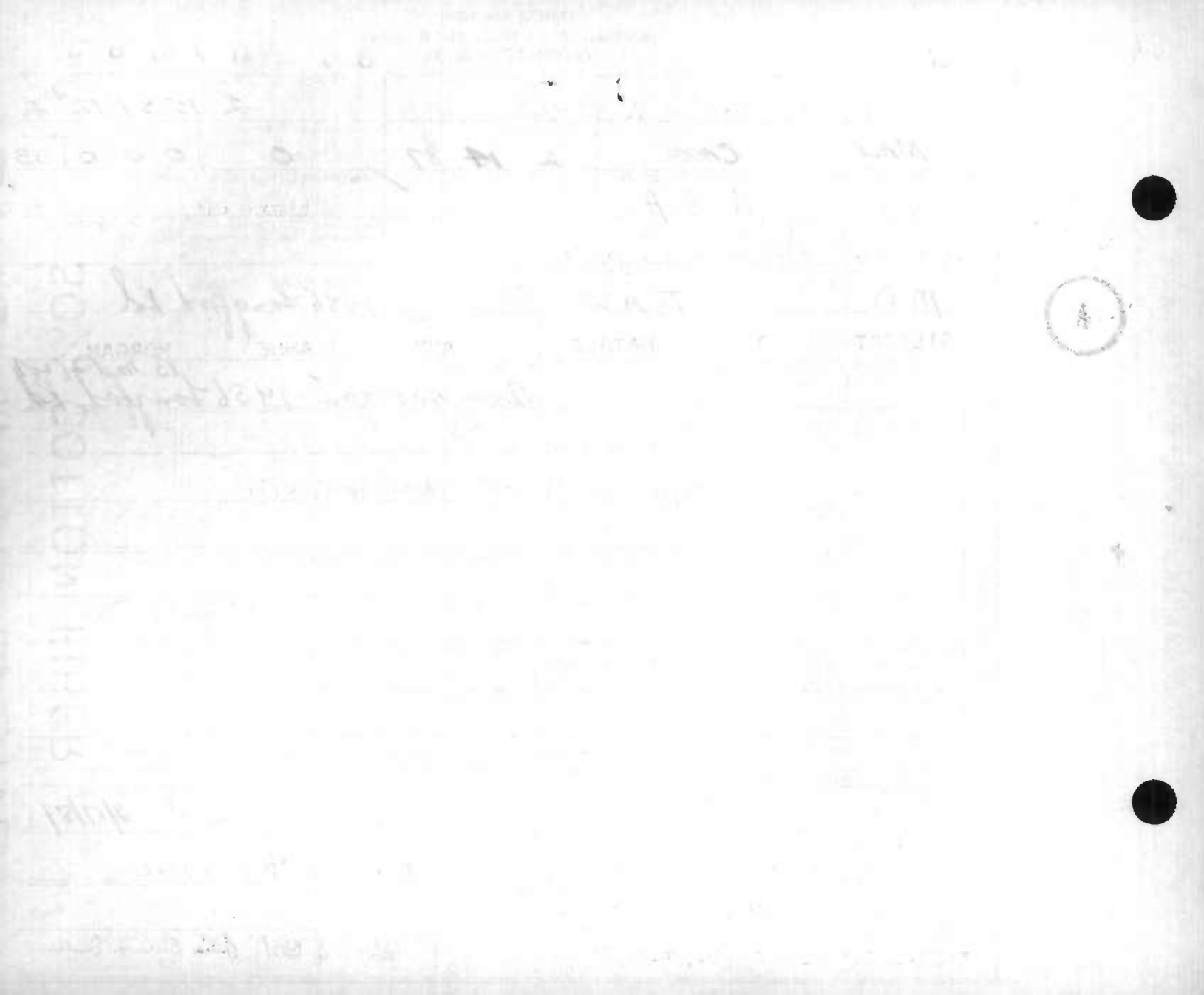
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) BABY BOY NATALE | | | | | 2a DATE OF DEATH
MONTH 2 DAY 15 YEAR 87 | | | | | 2b HOUR
12⁴⁵ AM | |
| 3 SEX
MALE | | 4 RACE
CAUC. | | 5 DATE OF BIRTH
MONTH 2 DAY 14 YEAR 87 | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS. 0 MONTHS 0 DAYS 0 HOURS 0 MIN. 53 | | | 7 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY) md. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MD 13b CITY OR TOWN BALTO. | | | | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c STREET ADDRESS / ZIP CODE
1456 Tanglewood Rd 21207 | | | | |
| 14 FATHER'S NAME
FIRST GILBERT MIDDLE A LAST NATALE | | | | | 15 MOTHER'S MAIDEN NAME
FIRST AMY MIDDLE ANNE LAST MORGAN | | | | | 16b SOCIAL SECURITY NO. | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b SOCIAL SECURITY NO. | | | | | 17 INFORMANT
ADDRESS 13 md 21 20
Amy Morgan - 1456 Tanglewood Rd | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) IMMATUREITY
DUE TO, OR AS A CONSEQUENCE OF
(b) MARKED ACUTE CHORIOAMNIONITIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | 19 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
James E Taylor DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
2/17/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES E. TAYLOR, M.D. | | | | | | | | 22e. ADDRESS
ST. AGNES HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | | 23b. DATE
3/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | | | 23d. LOCATION
BALTO., MD. 21229 STATE | | |
| 24 FUNERAL DIRECTOR
HUBBARD F. HOME BALTO., MD. 21229 | | | | | | | | 25a. DATE REC'D BY REGISTRAR
MAR 04 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | |

MEDICAL CERTIFICATION



3

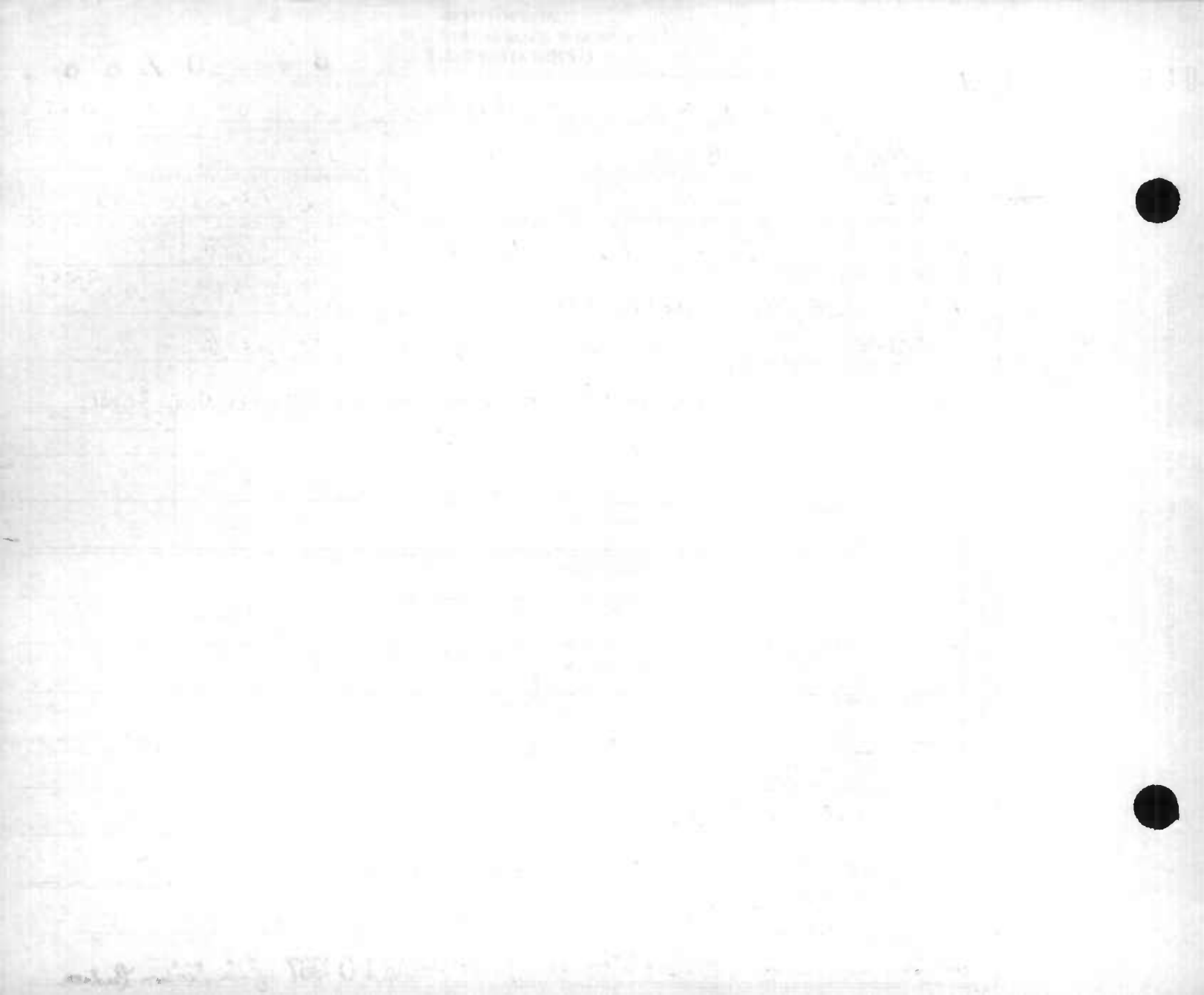
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 12 and 13 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Sydney W. Nicholson | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 1 87 | | 2b. HOUR
5:25 AM | | | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
9 26 50 | | 6. AGE (IN YEARS LAST BIRTHDAY)
36 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore C.T. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen. Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
GREENBURNIE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Orswell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Grace Elizabeth Howard | | 13e. STREET ADDRESS / ZIP CODE
11 Jackson Ave 21061 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
214 56 1280 | | 17. INFORMANT ADDRESS
MRS GRACE NICHOLSON 11 JACKSON AVE 21061 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Glaucoma</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 2/25 19 87 to 3/1 19 87, that (we) last saw the deceased alive on 3/1 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert L. Moss | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/1/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert L. Moss | | | | 22e. ADDRESS
30001 S. Hanover St. Balt | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
B | | 23b. DATE
3/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Peter | | 23d. LOCATION CITY OR TOWN COUNTY STATE
A A Co Md | | | |
| 24. FUNERAL DIRECTOR NAME
Joseph C. Rynn | | | | ADDRESS
2222 W 7th | | 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia S. Rynn | |



047418 MAR 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 must be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|----------------------------|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 87075666
REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST: John MIDDLE: Martin LAST: Nicholas (Nickol) | | | | | | | | | | 2a. DATE OF DEATH
MONTH: 3 DAY: 15 YEAR: 87 | | 2b. HOUR
5 A.M. | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH: 11 DAY: 17 YEAR: 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | 7. UNDER 1 YEAR
MONTHS: DAYS: HOURS: MIN. | | 8. UNDER 24 HRS
HOURS: MIN. | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 10. CITIZEN OF WHAT COUNTRY?
USA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore Wm. St. Michael's Hosp. Retirement Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Lamp Lighter | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | 13. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 14. USUAL RESIDENCE (IF HUSBAND OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
14a. STATE: Maryland 14b. COUNTY: Baltimore 14c. CITY OR TOWN: Baltimore | | 15. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 16. STREET ADDRESS / ZIP CODE
2730 Yarnall Road-21227 | | 17. FATHER'S NAME
FIRST: John M. MIDDLE: Nickol LAST: Carrie | | 18. MOTHER'S MAIDEN NAME
FIRST: Carrie MIDDLE: Hurtt LAST: | | 19. ADDRESS
John M. Ramsey - 2730 Yarnall Rd.-21227 | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 21. SOCIAL SECURITY NO.
214-10-6123 | | 22. INFORMANT
John M. Ramsey - 2730 Yarnall Rd.-21227 | | 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): CANCER OF LUNG.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 25. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
SUPERIOR VENA CAVAL SYNDROME, OLD CEREBRO VASCULAR ACCID. | | | |
| 26. DATE OF OPERATION | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 28. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 30. MEDICAL CERTIFICATION
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 31. SIGNATURE
Thalibani (M) | | 32. DATE SIGNED
3/16/87 | |
| 33. PHYSICIAN'S NAME (TYPE OR PRINT)
TASNEEM LAICHANI | | 34. ADDRESS
7220 PARK HEIGHTS AVE BALTO MD | | 35. ATTENDING PHYSICIAN
MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 36. STAFF PHYSICIAN <input type="checkbox"/> | | 37. MEDICAL DIRECTOR <input type="checkbox"/> | | 38. PHYSICIAN <input type="checkbox"/> | | | |
| 39. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 40. DATE
3-17-87 | | 41. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 42. LOCATION
CITY OR TOWN: Baltimore COUNTY: BALTO MD STATE: MD | | 43. FUNERAL DIRECTOR
NAME: John C. Miller, Inc. ADDRESS: 6415 Belair Road-21206 | | 44. DATE REC'D. BY REGISTRAR
MAR 17 1987 | | 45. REGISTRAR'S SIGNATURE | |

00-10-10

12-10-10

13-10-10

14-10-10

15-10-10

16-10-10

17-10-10

18-10-10

19-10-10

20-10-10

21-10-10

22-10-10

23-10-10

24-10-10

25-10-10

26-10-10

2010-10-10

10-10-10

10-10-10



4

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| #1 G626, 4/9/87 by F.H. GBJ. | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07001 | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Mattie Bell Nichols | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 31, 1987 | | | | 2b. HOUR
9:55 P.M. | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
Dec 17 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Garrison Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3814 Old Frederick Rd 21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Morwee Mims | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mattie Perry | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
213-22-9471 | | 17. INFORMANT
Annie B. Clark | | ADDRESS
3814 Old Frederick Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Unsupers
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute renal failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hours
2 weeks
2 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Decubitus ulcer; Dermatitis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 15 March, 19 87, to 31 March, 19 87, that (I) (we) last saw the deceased alive on 31 March, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
D. Jung, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
31 March 1987 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. Jung | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
4/7/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H West | | | | ADDRESS
4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 6 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

4/10

048447 MAR 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR | | | | | 2b. HOUR
PM | |
| Nellie Nitz | | | | | 3/21/87 | | | | | 705 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-18-1893 | | 6. AGE
YRS
93 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 1 YEAR
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
U.S. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Edgewood Nurs Home-Meridan 6000 Bellona | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3501 St. Paul St. 21218 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Francis M. Simpson | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary A. 4d9. | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
219-26-1468A | | | 17. INFORMANT
ADDRESS
Mr. Herbert Witz 1406 Fidelity 210 N. Charles St. 2201 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>SINILE DEMENTIA</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL VASCULAR INSUFFICIENCY</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD.</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/21/87</u> to <u>3/21/87</u> that (I) (we) last saw the deceased alive on <u>3/21/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Anthony F. Capozza MD | | | | | 22c. DATE SIGNED
3/23/87 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANTHONY F. CAPOZZA | | 22e. ADDRESS
4214 MANORWOOD DR CHES ARM | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

4

046410 MAR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

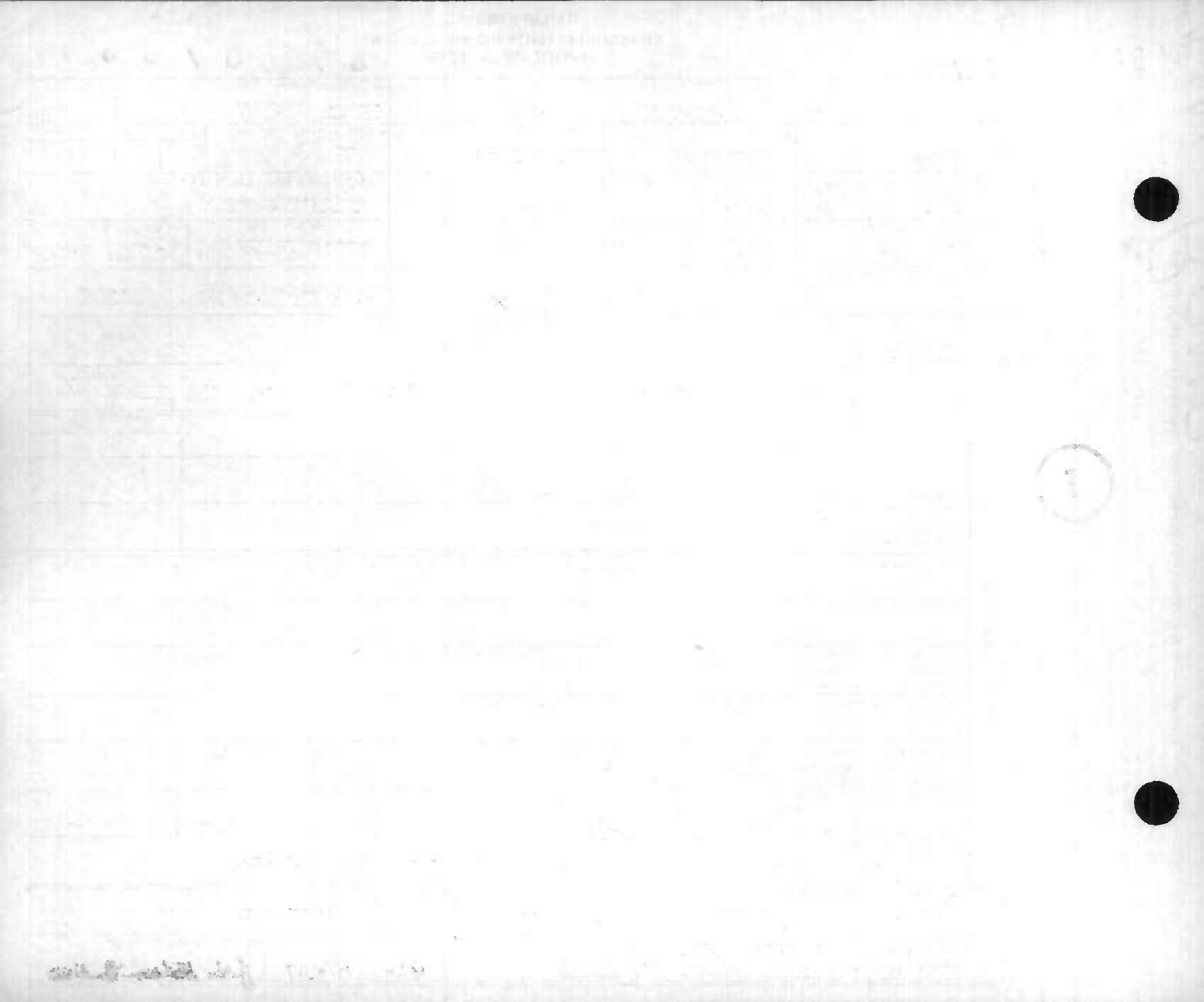
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please bring the permit to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HENRY GEORGE NOLL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 2 1987 | | | 2b. HOUR
10:15 a.m. | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 7 1914 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
72 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4335 SHELDON AVEN. 21206 | | | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
SUPPLY CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
BALTO. CITY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE NOLL | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA Kessler | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WW II | | | | | 16b. SOCIAL SECURITY NO.
219-01-9019 | | 17. INFORMANT ADDRESS
DOLORES EVERHART (DGHTER) 5032 ERDMAN AVE. 21205 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiomyopathy</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December</u> , 19 <u>86</u> , to <u>February</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>January</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Matthew Ruff</u> | | | | | DEGREE <u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/4/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. MATTHEW WOLF | | | | | 22e. ADDRESS
Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
3/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GREENMOUNT | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR
SCHIMONEK FUNERAL HOME, I NC.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 06 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

BP



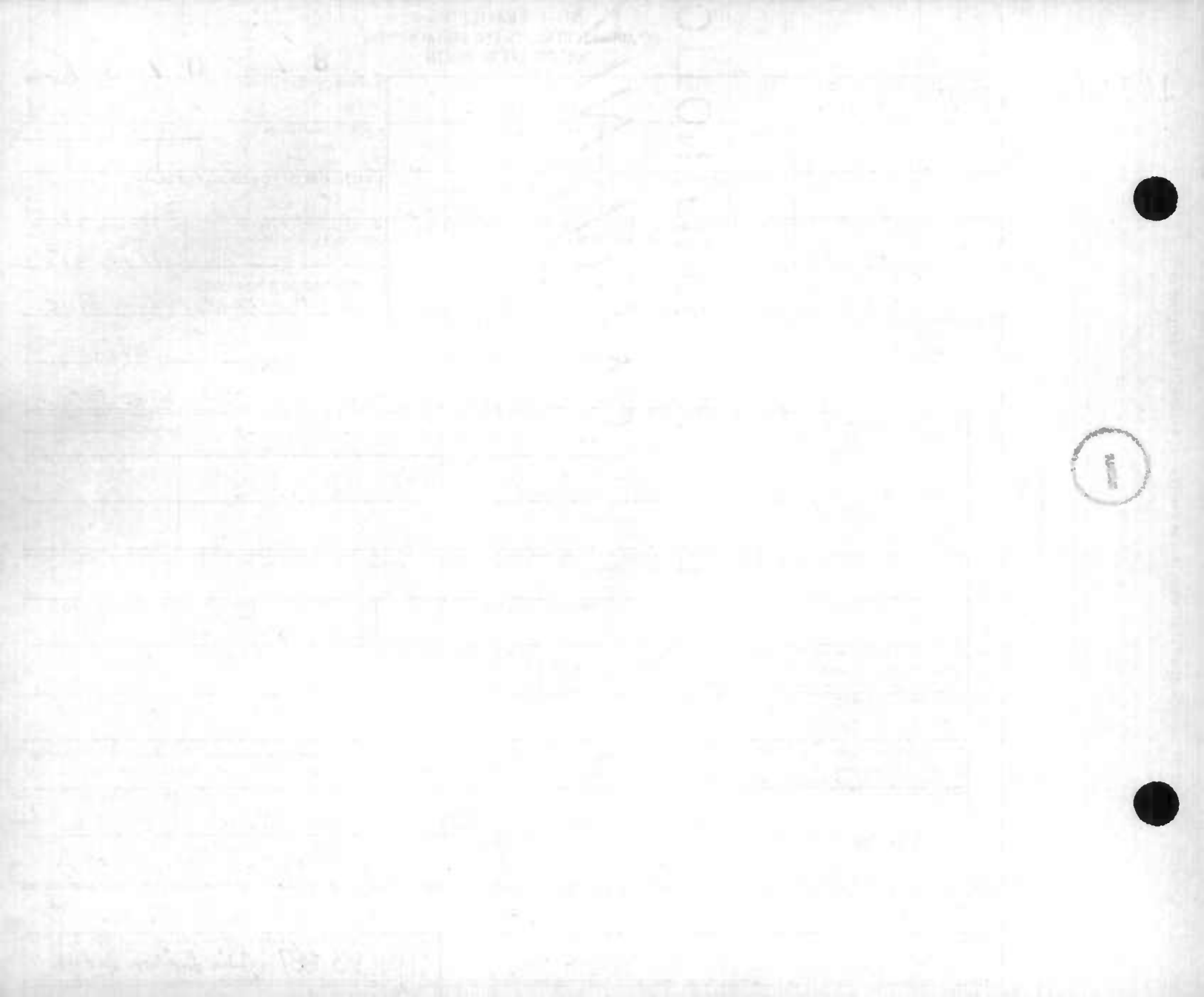
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|------------------------------------|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 8 REG. NO. 07670 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
James Norris | | 2a. DATE OF DEATH MONTH DAY YEAR
03 10 87 | | 2b. HOUR
12:54 AM | | | | | |
| 3 SEX
M | 4 RACE
B | 5. DATE OF BIRTH MONTH DAY YEAR
12 23 31 | | 6 AGE (IN YEARS LAST BIRTHDAY)
55 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
County Balt. City MD | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carr Lowrey Glass | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
Md. | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5500A Belle Ave 21215 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Henry Norris | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Missie Smith | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b SOCIAL SECURITY NO.
226-36-7813 | | 17 INFORMANT ADDRESS
Geneva Norris 5500A Belle Ave | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest / cardiogenic shock | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction. Atherosclerosis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3/4 19 87, to 3/10 19 87, that (I) (we) lost saw the deceased alive on 3/10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
N. Brookins-Reddix MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/10/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
N. Brookins-Reddix MD | | 22e ADDRESS
Sinai Hospital, Belvedere at Greenspring | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/13/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Owings Mills, Md. | | | |
| 24 FUNERAL DIRECTOR NAME
Wm C March F/H West | | | | ADDRESS
4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Roads | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <div> <p>FOR
1- STATE
REGISTRAR</p> </div> <div> <p>REG. NO. 87 07671</p> </div> </div> | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Kate | | | FIRST KATE MIDDLE LAST NORWOOD | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-29-87 | | 2b. HOUR 5:25 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
11 24 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Joseph Richey House | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Stock Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6401 Loch Raven Blvd. 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
James Edward Norwood | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Katherine Guinn | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
214-01-3490 | | 17. INFORMANT ADDRESS
J. Hastings 6401 Loch Raven Blvd. 21239 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxia
DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Colon | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos
1 yr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-3 , 19 87 , to 3-29 , 19 87 , that (I) (we) last saw the deceased alive on 3-29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert C. Irwin, MD | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-29-87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert C. Irwin, MD | | | | | 22e. ADDRESS
828 N. Eutan St. Balto. Md 21201 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
4-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Mitchell-Wiedefeld Home 6500 York Road 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 1 1987 | | 25b. REGISTRAR'S SIGNATURE
Frederick R. ... | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07672

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Frances | | K. Novick | | March 13, 1987 | | | | 3.A. M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Female | | White | | May 15, 1895 | | 91 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| New York | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 6320 Greenspring Ave. | | | | Housewife | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6320 Greenspring Ave. 21209 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | |
| Louis Keller | | | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | 216-20-1855 | | Mrs. Carol N. Kersten Pikesville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolus -</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic fibrillation</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary thrombosis</u> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>Coronary thrombosis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> 19 <u>87</u> , to <u>3/13</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>GARY B. RUPPERT</u> | | | | MD | | | | 3/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| GARY B. RUPPERT | | | | 301 St. Paul Pl. Balto. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | Mar. 14, 87 | | Carroll Cremation | | Hampstead, Md. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS
Eline Funeral Home Reisterstown, Md. 21136 | | | | | | MAR 17 1987 | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The following physician that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed, it must be retained by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene placed in the proper folder, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07673

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) James Stone NOYES | | 2a. DATE OF DEATH MONTH DAY YEAR 3 28 87 | | 2b. HOUR 10:40 P.M. | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 6 23 11 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH DC | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore GEN. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRIEST. | 12b. KIND OF BUSINESS OR INDUSTRY Religious | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3803 4th Street 21225 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elliott V. NOYES | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY L. CAMALIER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO IF YES, GIVE WAR OR DATES - | | 16b. SOCIAL SECURITY NO. 220442860 | | 17. INFORMANT ADDRESS D.C. 20015
Albert Noyes 5415 Connecticut Ave Washington | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Pulmonary Arrest.
DUE TO, OR AS A CONSEQUENCE OF
(b) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Pulmonary Edema | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3/2 1987 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2 1987 , to 3/2 1987 , that (I) (we) last saw the deceased alive on 3/2 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE TERESA WONG MD | | DEGREE | | 22c. DATE SIGNED 3/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 889 N | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/6/87 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | |
| 23d. LOCATION Baltimore | | A.COUNTY A.A. | | STATE Md | |
| 24. FUNERAL DIRECTOR George J. Gonce | | 4001 Ritchie Hwy Balto Md | | 25a. DATE REC'D BY REGISTRAR MAR 04 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | |

7990

10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this page to the funeral director. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 87 REG. NO. 07674 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MARGARET E. | | MIDDLE | | LAST OBERENDER | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | |
| 3. SEX F | | 4. RACE C | | 5. DATE OF BIRTH MONTH DAY YEAR 3 7 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH BALT | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN'L HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY Tailoring | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY BALT | | 13c. CITY OR TOWN BALT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 600 LIGHT ST 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARCLEANA OZMON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn. | | 16b. SOCIAL SECURITY NO. 217099482 | | 17. INFORMANT ADDRESS 303 E. Hamburger St. Ms. Margaret Cooper Balto., Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) LUNG CANCER
DUE TO, OR AS A CONSEQUENCE OF
(c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD, DM | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10 19 87, to 3/4 19 87, that (I) (we) last saw the deceased alive on 3/4/87 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J. A. GIRALT DEGREE | | | | | | 22c. DATE SIGNED 3/4/87 | | 22e. ADDRESS 3001 S. HANOVER | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 3-5-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME State Anatomy Board ADDRESS Balto., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 20 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall | |

BP



07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM TM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | | | |
|--|--|------------------------------------|--|--|--|---|--|---|--|---|--|-------------------|--|
| FOR
1- STATE
-- REGISTRAR | | Item #5, Film #G626
4/8/87 I.J. | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. 07675 | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | FIRST PETERIS
MIDDLE
LAST Oborenko | | | | 2a. DATE KNOWN OF DEATH
ESTI- MATED <input checked="" type="checkbox"/> 3-30-87
MONTH DAY YEAR | | | | 2b. HOUR
M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR 3 7 19 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 68 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
3-30-87
MONTH DAY YEAR | | 7d. HOUR
4:30P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Latvia | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4201 Pennington Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Plastic Molder | | 12b. KIND OF BUSINESS OR INDUSTRY
Westinghouse | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4201 Pennington Ave. 21225 | | | |
| 14. FATHER'S NAME
FIRST U N K N O W N
MIDDLE
LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST Agnes
MIDDLE
LAST Unknown | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-32-1608 | | 17. INFORMANT
ADDRESS
Tekla Oborenko 505 University Pkwy. 21210 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
<u>cirrhosis of liver</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 3-31-87 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Cremation | | | | 23b. DATE
4/6/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process Crem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | | | ADDRESS
21229
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
APR - 6 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Swenson-Padua</u> | | | | | |

4/10



046013 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07676

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
HAROLD W. O'BRIEN, SR. | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 1, 1987 | | 2b. HOUR
9:00 P.M. | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
12/14/15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hosp Corp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Langenfelder |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY
- | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3465 Mayfield Ave. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George O'Brien | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hersie Lee Fields | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-01-0840 | | 17. INFORMANT
ADDRESS
Michael O'Brien, Sr. (son) same add. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>
PROBABLE SEX SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 18 87</u> to <u>MARCH 1 87</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 1, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Kang Sun Lee</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>3/1/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KANG SUN LEE | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTO., MD. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chimunek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
MAD 03 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

BP _____



48212 MAR 26

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07671

| | | | | | |
|---|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NORMA E. OGG | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 18, 1987 | | 2b. HOUR
10:18 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
December 6, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. STREET ADDRESS / ZIP CODE
2211 W. Rogers Avenue 21209 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George A. Ogg | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E. Englar | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212 10 6942 | | 17. INFORMANT ADDRESS
The Wesley Home. 2211 W. Rogers Ave. 21209 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
885 IMMEDIATE CAUSE (a) Respiratory Arrest, Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Metabolic Acidosis, Coronary ischemia
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute Renal Failure, Chronic Renal failure
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Ileus, Angina, Recent (L) Femur Fracture | | | | | |
| 19a. DATE OF OPERATION
3/14/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
(L) Femur Fracture | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 3 14 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
Slipped and Fell | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
retirement home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2211 W. Rogers Avenue Baltimore, Maryland | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 14, 1987, to March 18, 1987, that (I) (we) last saw the deceased alive on March 18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
John P. Serlemitsos | | DEGREE M.D.
CERTIFICATION APPROVED BY MEDICAL EXAMINER
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John P. Serlemitsos | | 22e. ADDRESS
Union Memorial Hospital - Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | |
| 24. FUNERAL DIRECTOR
NAME
Burgee-Henss Funeral Home, 3631 Falls Rd 21211 | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville, Balto. Co. Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Handwritten notes at the top of the page, including a date "1911" and various illegible scribbles.

Main body of handwritten text, appearing as several lines of cursive script, mostly illegible due to fading.

Bottom section of the page containing additional handwritten notes and possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 8 / REG. NO. 07013 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Joseph | | FIRST MIDDLE LAST
Oleszczuk | | 2a. DATE OF DEATH MONTH DAY YEAR
3-1-87 | | 2b. HOUR
1:10 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 5, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
87 | | IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City Md. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital Hosp. St. Paul St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Long Shoreman | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
314 S. Chester St. 21231 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216-01-6136 | | 17. INFORMANT ADDRESS
Irene Jaworski 8151 Clyde Bank Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) possible no sepsis
(c) Klebsiella urinary tract infection | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs
3 days
3 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
metastatic colon cancer, recurrent bowel obstruction, congestive heart failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Melba Beine MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-1-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Melba Beine | | 22e. ADDRESS
Mercy Hospital Baltimore MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore MD. | | | |
| 24. FUNERAL DIRECTOR
Walter F. John M. Weber & Sons, Inc. | | ADDRESS
401 S. Chester St. | | 25a. DATE RECD. BY REGISTRAR
MAR 02 1987 | | 25b. REGISTRAR'S SIGNATURE
James Anderson-Randall | | | |

MEDICAL CERTIFICATION

SECRET

1. The first part of the report covers the period from January 1, 1968, to March 31, 1968. It discusses the activities of the group during this time, including the recruitment of new members and the planning of various operations.

2. The second part of the report covers the period from April 1, 1968, to June 30, 1968. It discusses the activities of the group during this time, including the recruitment of new members and the planning of various operations.

3. The third part of the report covers the period from July 1, 1968, to September 30, 1968. It discusses the activities of the group during this time, including the recruitment of new members and the planning of various operations.

4. The fourth part of the report covers the period from October 1, 1968, to December 31, 1968. It discusses the activities of the group during this time, including the recruitment of new members and the planning of various operations.

CONFIDENTIAL

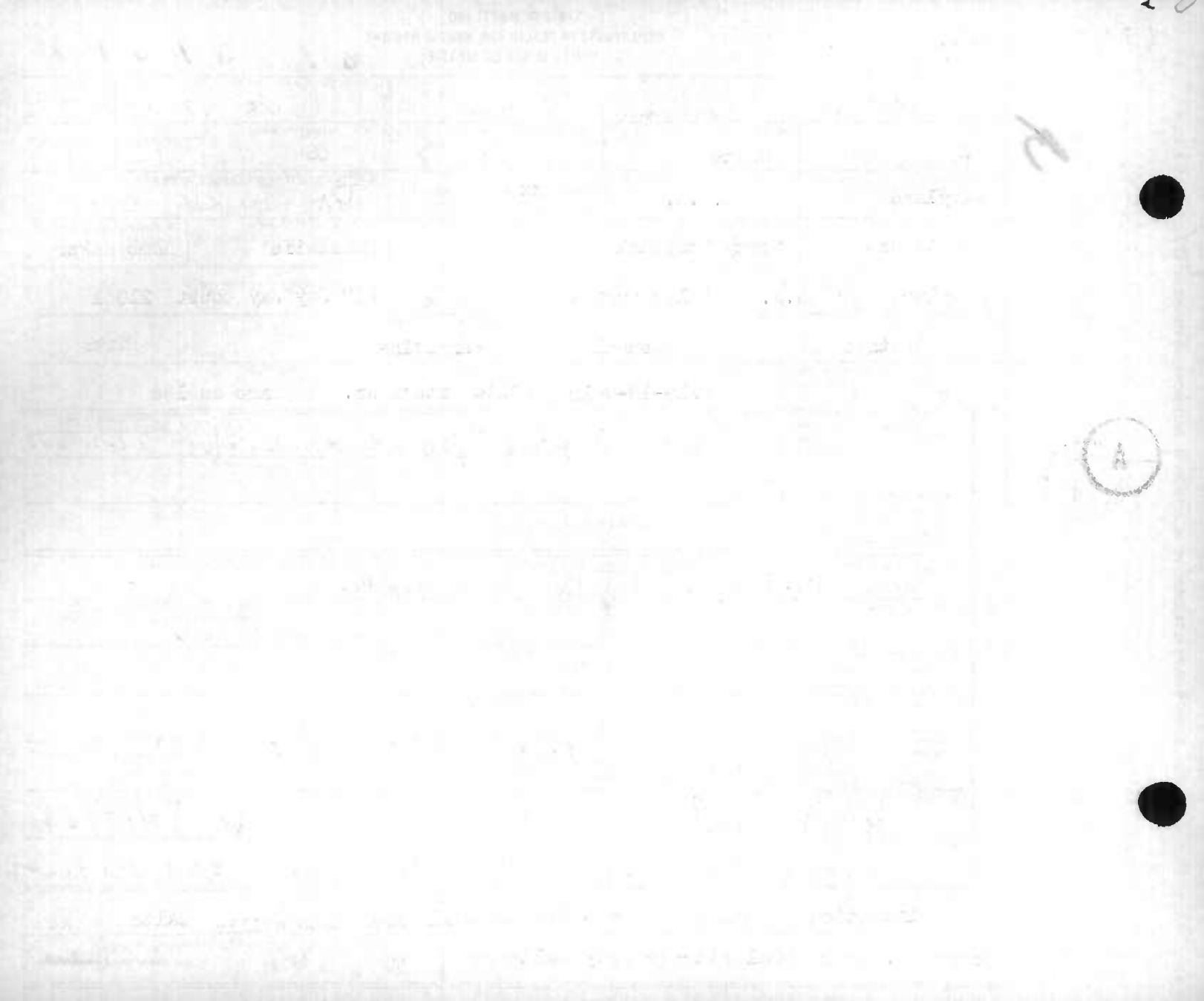
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed pages. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MIRIAM Catherine Ortega | | | | | 2a. DATE OF DEATH
MONTH 03 DAY 18 YEAR 87 | | 2b. HOUR
1250 PM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 07 DAY 03 YEAR 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home Maker | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY A.A. 13c. CITY OR TOWN Glen Burnie | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
287 Jay Jay Court 21061 | | |
| 14. FATHER'S NAME
FIRST Gustave MIDDLE LAST Reechel | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Bernadine MIDDLE LAST Parks | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-18-0412 | | 17. INFORMANT
Julio Ortega Jr. | | | ADDRESS
Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gram Negative Sepsis w. the respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Chronic Renal Failure, Congestive Cardiomyopathy | | | | | | | | | |
| 19a. DATE OF OPERATION
3/18/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Chronic Renal Failure | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART 1 OR PART 2)
 | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/18/87 to 3/18/87 , that (I) (we) lost
saw the deceased alive on 3/18/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John F. Cary | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/19/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN F. CARY MD | | | | 22e. ADDRESS
301 ST PAUL STREET BALTO. MD 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
3/20/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Park | | 23d. LOCATION
CITY OR TOWN Catonsville COUNTY Balto STATE Md | | | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto Md | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | 25b. REGISTRAR'S SIGNATURE
Julio Davidson-Randall | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. This permit is required for the removal of the body from the residence. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18, 19 or 20 is any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ALEX OSBORNE | | | | | 2a. DATE OF DEATH
MONTH 3 / DAY 4 / YEAR 87 | | 2b. HOUR
3:05A.M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH Oct. DAY 26 YEAR 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | |
| 7a. BIRTHPLACE
(COUNTRY) N. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
N. Charles General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
farmer | | 12b. KIND OF BUSINESS OR INDUSTRY
farming | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. CITY OR TOWN Middletown | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2336A Hollow Rd. 21769 | | |
| 14. FATHER'S NAME
FIRST Hugh MIDDLE Osborne LAST Osborne | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Cora MIDDLE Turnmar LAST Turnmar | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
218-30-4974 | | 17. INFORMANT
Cora Musser | | ADDRESS 21769 Middletown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA & RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) VENTRICULAR ARRYTHMIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
CARCINOMA OF PROSTATE, CVA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 87 , to 3/4 19 87 , that (I) (we) last saw the deceased alive on 3/4 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
A.C. Chouvalit, M.D. | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.C. CHOUVALIT, M.D. | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Mar. 6, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Mem. Park | | 23d. LOCATION
CITY OR TOWN Sykesville COUNTY Carroll STATE Md. | | | |
| 24. FUNERAL DIRECTOR
Thompson Funeral Home | | | | ADDRESS
Middletown, Md. 21709 | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

BP

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JAMES OWENS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-13-87 | | | 2b. HOUR
1:18 PM | |
| 3. SEX
M | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
11-29-11 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
75 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GEN. HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 21225
2303 Terra Firma Rd | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
GEORGE OWENS | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CARRIE TAYLOR | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
425-031-75 | | 17. INFORMANT ADDRESS
JAMES M. OWENS 21225
627 POUNDVIEW RD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Pulmonary - Arrer
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPTIC SHOCK.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) RENEC FAILURE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
LIVER FAILURE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-2, 1987, to 3-13, 1987, that (I) (we) last saw the deceased alive on 3-13-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Hayit Swigh | | | | | DEGREE MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/13/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN HARNEY MD | | | | | 22e. ADDRESS
SOUTH BALTIMORE GEN HOSP | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balt. MD | | | |
| 24. FUNERAL DIRECTOR NAME
MARCH FUNERAL HOME | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | | 25b. REGISTRAR'S SIGNATURE
Lisa Davidson | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all numbers, dates, and times from the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 REG. NO. 682 | | 9 REG. NO. 07 | | 10 REG. NO. 682 | | 11 REG. NO. 682 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
GEORGIA M OXENDINE | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 30 87 | | 2b. HOUR MIN.
15:15 PM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
11 08 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Harry Ruck | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Charlotte Hocks | | | | 13e. STREET ADDRESS / ZIP CODE
833 N. Woodington Rd. 21229 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
051-20-0301 | | 17. INFORMANT ADDRESS
Harriet Greene 833 N. Woodington Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ATHEROSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2-3 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from MAR 26, 19 87, to MAR 30, 19 87, that (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Bert F. Morton | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Mar 31, 1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERT F. MORTON | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
Wm. C. March F/H West | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 3 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

4/9



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

UNK.#87-28

REG. NO. 7683

| | | | | | | | | |
|---|---------------------|---|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dennis J. Pacheco | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
3-2 1987 | | | 2b. DATE OF DEATH
MONTH DAY YEAR
3-2 1987 | | |
| 3. SEX
Male | 4. RACE
Hispanic | 5. DATE OF BIRTH
MONTH DAY YEAR
7 1 1963 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
23 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3-2 1987 | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital - STU | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
Education |
| 13a. STATE
Rhode Island | | | 13b. COUNTY
Providence | | 13c. CITY OR TOWN
Providence | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jose Pacheco | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Aide Munoz | | | 13e. STREET ADDRESS
102 Ontario Street | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | | 17. INFORMANT
ADDRESS
Rhode Island
Hayde Pacheco 102 Ontario St. Providence. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Gunshot Wound of Head (Unspecified)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b).
DUE TO, OR AS A CONSEQUENCE OF
(c). | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOURS MONTH DAY YEAR
8:20 P.M. 3-2 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject was shot | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
parking lot | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
12 E. Bend Ct., Woodlawn, Baltimore Co., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | | TITLE (SPECIFY)
Assistant Medical Examiner | | | DATE SIGNED
3-3-87 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-9-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakland Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cranston, Providence, Rhode Island | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Marzullo Funeral Service Upperco, MD. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 9 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PASS, AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07 84
25M
BP
DHMH - 17
(VR A15 ME (5))

047036 MAR 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7684

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Emanuel E. Pack, SR | | | 2a. DATE OF DEATH
MONTH DAY YEAR 3 7 87 559P M | | |
| 3 SEX
M | 4 RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR 4 15 09 | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore Co. MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven VA Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) Stevendore | | 12b. KIND OF BUSINESS OR INDUSTRY
Shipping |
| 13a. STATE
MD. | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Jack Pack | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Elenore EPDS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO.
217-05-5018 | 17. INFORMANT
ADDRESS Alma Pack 4224 Loch Raven Blvd | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) 20 pulmonary embolus (massive)
DUE TO, OR AS A CONSEQUENCE OF
(c) versus myocardial infarction
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
SIP CVA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from 3/7 19 87 , to 3/7 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased 3/7 19 87 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (II) we did <input type="checkbox"/> did not view the body after death. | | | | | |
| 22b. SIGNATURE
Linda E. Barr | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Linda E. Barr | | 22e. ADDRESS
Dept. of Medicine, Loch Raven VA Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Bural | 23b. DATE
3-13-87 | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | 23d. LOCATION
CITY OR TOWN COUNTY BALTO. MD | |
| 24. FUNERAL DIRECTOR
NAME March Funeral Home ADDRESS 1101 E. NORTH AVE | | | 25a. DATE REC'D. BY REGISTRAR
MAR 12 1987 | | 25b. REGISTRAR'S SIGNATURE
Linda E. Barr |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the coroner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be destroyed for the State Health Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medication should be notified at once.

MEDICAL CERTIFICATION

9/21/2006

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07685 | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
AKA
JEAN | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 26 1987 | | 3. SEX
Female | |
| 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 11, 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 10. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 14. USUAL OCCUPATION
(TYPE OF WORK OR MOST COMMON WORKING INDUSTRY)
Machine Operator | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
Maryland | | 15b. COUNTY
Baltimore | | 15c. CITY OR TOWN
Baltimore | |
| 16. FATHER'S NAME
FIRST MIDDLE LAST
Haven C. Simpson | | 17. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Olie Norton | | 18. STREET ADDRESS / ZIP CODE
35 N. Duncan St. 21231 | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 20. SOCIAL SECURITY NO.
212 36 6235 | | 21. INFORMANT
Brenda G. Mullins | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF (c) PORTAL HYPERTENSION | | 23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min.
1 hr. | | 24. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
LIVER CIRRHOSIS, COAGULOPATHY | |
| 25. DATE OF OPERATION
1987 | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED
CHURCH HOSPITAL CORPORATION | | 27. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 31. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 32. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 33. LOCATION
CITY OR TOWN COUNTY STATE | |
| 34. I certify that (this hospital) attended the deceased from MARCH 23 , 19 87 , to MARCH 26 , 19 87 , that (I) (we) lost
saw the deceased alive on MARCH 26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 35. SIGNATURE
Carol S. Ramsey
D.O. ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 36. DATE SIGNED
3/27/86 | |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT)
CAROL S. RAMSEY, D.O. | | 38. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MARYLAND | | 39. DATE RECEIVED BY REGISTRAR
MAR 30 1987 | |
| 40. BURIAL, CREMATION, REMOVAL
(IF BURIED)
Cremation | | 41. DATE
3/27/86 | | 42. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | |
| 43. FUNERAL DIRECTOR
Bruzdinski Funeral Home | | 44. ADDRESS
PA 1407 Old Eastern Ave | | 45. REGISTRAR'S SIGNATURE
David | |

288

July 11, 1958

July 11, 1958

July 11, 1958

White

White

Baltimore City

X

101

West Virginia

Technical School

Church Hospital

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X

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REG. NO.

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| FOR STATE 4/28/87 sjb
REGISTRAR by Medical Examiner | | | | | | | | | | DEPARTMENT OF HEALTH AND METAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 686 | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARIE E. PALLIKAL | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3-12-87 | | | | | | | | | | 2b. HOUR 10:15 | | | | | | | | | | | | | | | | | | | |
| 3. SEX F 4. RACE ASIAN 5. DATE OF BIRTH MONTH DAY YEAR 11 18 86 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 3 25 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 8. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | | | | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13b. STREET ADDRESS 5507 TODD AVE 21206 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Goy PALLIKAL | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAYA THOMAS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. None | | | | | | | | | | 17. INFORMANT ADDRESS Goy Pallikal 5507 TODD AVE 21206 | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity with complications
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2-8 1987 P.M. | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) endotracheal tube kinked | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hospital | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Sinai Hospital Baltimore Maryland | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | TITLE (SPECIFY) Assistant | | | | | | | | | | DATE SIGNED 3-13-87 | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margaret A. Korell M.D. | | | | | | | | | | M.D. Assistant | | | | | | | | | | MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margaret A. Korell M.D. | | | | | | | | | | ADDRESS 111 Penn Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | | | | | 23b. DATE 3-13-87 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Smallwood Price | | | | | | | | | | ADDRESS 322 S. High St. | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR MAR 17 1987 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE DELAY. **GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.** **GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER.** **RETAIN PAGES 6 AND 7 FOR YOUR FILES.** **PAGES 8 AND 9 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH.** **PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT.** **THIS IS NOT A PART OF VITAL RECORDS.** **201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201** **PRIOR TO BURIAL, CREMATION, OR REMOVAL.**

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(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07687

| | | | | | |
|--|------------------|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Anthony Bryan Panutty | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
March 3 24 1987 | | 2b. HOUR
M
A |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 19, 1961 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
25 YRS. | 7. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
March 3 24 1987 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Tony's Lounge | | MD | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ruben Tony Pannutty | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Deanna J. Wilson | | 16. ADDRESS
211 Catalfa Ave.
Pasadena, Md. 21122 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
NA | | 17. INFORMANT (Mother)
Deanna J. Triplett | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of head (handgun)</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
4:34 P.M. 3 23 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Self inflicted | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 100 nr. Waterford Rd. Glen Burnie A.A.Co, MD. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
Deputy Chief | | MEDICAL EXAMINER
DATE SIGNED 3/25/87 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St. Balto.MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
March 28, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | |
| 23d. LOCATION
CITY OR TOWN
Glen Burnie | | 23e. COUNTY
A A Co. Md. | | | |
| 24. FUNERAL HOME
NAME
Singleton Funeral Home | | 24b. ADDRESS
Glen Burnie, Maryland | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | |
| 25b. REGISTRAR'S SIGNATURE
 | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

048213 MAR 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

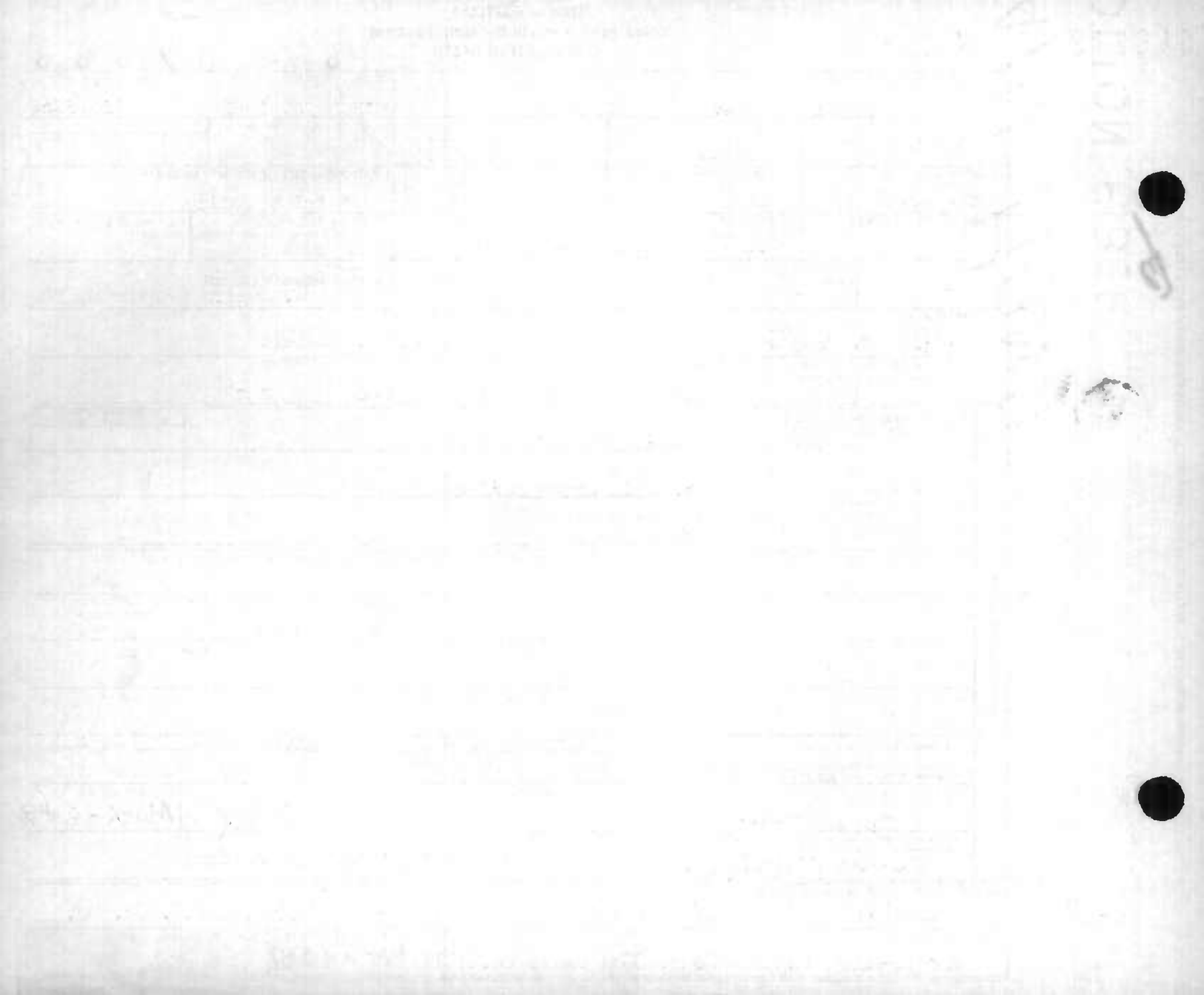
07088

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
OTELIA V. PAQUETTE | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 20, 1987 | | 2b. HOUR
12:55am | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 30, 1906 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
2211 W. Rogers Avenue 21209 | | | |
| 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. CITY OR TOWN
Baltimore | | 13d. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md
13b. COUNTY
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William P. Vaughan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Harriet L. Daniels | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
238 58 8651 | | 17. INFORMANT ADDRESS
The Wesley Home same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Multiple organ failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Liver failure</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 5, 1987</u> to <u>March 20, 1987</u> , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on <u>March 20, 1987</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | 22b. SIGNATURE
Tzong Hwang
DEGREE
Tzong Hwang | |
| 22c. DATE SIGNED
March 20, 87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Tzong Hwang | | 22e. ADDRESS
c/o Maryland General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
3/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westview, Balto. Co. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Burgee-Henss Funeral Home, 3631 Falls rd. 21211 | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Pandora | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on any item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 87 REG. NO. 07689 | |
|---|--|---|--|---|--|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARY LOUISE PARKER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 24 87 | | | 2b. HOUR
1400 AM | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
8 29 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Lansdowne | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
423 Fifth Avenue, 21227 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles F. Saunders | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lottie Heilman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
215-12-1408 | | 17. INFORMANT ADDRESS
Walter J. Parker, 423 Fifth Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic colonic carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, EARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/16 , 19 87 , to 3/24 , 19 87 , that (I) (we) lost above, the deceased alive on 3/24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ziad R. Far | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ziad R. Far | | | | 22e. ADDRESS
St Agnes Hospital 900 Calver Avenue | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
3/27/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc., | | | | ADDRESS
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rudie | | | |

MEDICAL CERTIFICATION

BP

046423 MAR-1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07690

| | | | | | | | | | | | |
|--|---------|------------------|--|----------------|------------------|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Eddie | | | M. Parks | | | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 3/ 3/ 1987 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | | 7d. HOUR | | |
| M | Black | MONTH DAY YEAR | 78 YRS. | MONTHS DAYS | HOURS MIN. | 3/ 3/ 1987 | | | 9:57 P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| South Carolina | | | U.S.A. | | | | | | Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | Bcn Secour Hospital | | | Labor | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Md. | | | | | | Balto. | | | 2530 Edmondson Ave. 21223 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| Vigil | | | Parks | | | Rosa Lee Hollis | | | 214-26-0212 | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| Eula Freeman | | | 2530 Edmondson Ave | | | | | | | | |
| 20. AUTOPSY? | | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 8/47 | | | 5:20 P.M. 3/3 1987 | | | subject pedestrian struck by auto | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | street | | | 2000 Blk. Edmondson Ave., Balto. City, Md. | | | | | |
| 22b. DATE | | | 22c. NAME OF CEMETERY OR CREMATORY | | | 22d. LOCATION | | | 22e. REGISTRAR'S SIGNATURE | | |
| 3-7-87 | | | MT. Zion | | | Balto. | | | MAR 06 1987 | | |
| 23a. BURIAL, CREMATION, REMOVAL (COPY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| Burial | | | 3-7-87 | | | MT. Zion | | | Balto. Md. | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | 25c. REGISTRAR'S SIGNATURE | | |
| Oden + Gibson | | | 1631 Druid Ave. | | | MAR 06 1987 | | | J. B. Borden | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE RETURNED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

046372 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified before burial or cremation.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RAYMOND JOSEPH PASTERNAK | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 4, 1987 | | | 2b. HOUR
6:45^PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
December 2 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY
Lumber Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3109 Cornwall Rd. 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael Pasternak | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maryanna Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-24-1798 | | 17. INFORMANT
ADDRESS
Helen Pasternak 3109 Cornwall Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CANCER COLON
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
ANAEMIA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 24 87 , to MARCH 4 87 , that (I) (we) lost
saw the deceased alive on MARCH 4 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>George Thomas</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE THOMAS MD. | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-7-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
JOHN M. WEBER & SONS INC. 401 S. CHESTER ST. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 06 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

100-10000

10

10

100% COTTON LIME

100-10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07692 | | | | | | | |
|---|--|--|--|--|--|---|-------------------------------------|---|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mildred G Patterson | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 9, 1987 | | | | 2b. HOUR
3 P.M. | | | |
| 3. SEX
Female | | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 08 1909 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deaton Hosp and Medical Cent | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | |
| 13a. STATE
Maryland | | | | | | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Middle River | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
823 Chester Rd. 21220 | |
| FATHER'S NAME
FIRST MIDDLE LAST
Silvester Schnaber | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Kirsch | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO.
201 20 6740 | | 17. INFORMANT
Marie Schap | | | 827 DE Chester Rd.
Baltimore, Md. 21220 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer cervix
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 yrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
malnutrition | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/9 87 to 3/9 87 , that (I) (we) last saw the deceased alive on 3/9 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Gladue, MD | | | | | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/9/87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Cremation | | | 23b. DATE
3/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Brudzinski Funeral Home | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 12 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Fenderson-Randall | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Thomas Payne | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 4 87 | | 2b. HOUR
4:42 PM | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
02 13 19 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
68 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Va | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mt. Vernon Care Ctr. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
— |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD. | 13b. COUNTY
— | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1615 Homewood Ave. 21202 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CALLE — PAYNE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA — CARTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unknown | | 16b. SOCIAL SECURITY NO.
223-20-8111 | | 17. INFORMANT
ADDRESS
Willie Mae Brown - Niece
Baltimore, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>—</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>—</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Left Hemisphere, Congestive Heart Failure.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11.17.1983</u> to <u>3.4.1987</u> , that (I) (we) last saw the deceased alive on <u>2.14.1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>S.D. AUJLA</u> | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3.5.87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
<u>5400 OLD COURT RD RANDALLSTOWN MD 21133</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(RECEIVED)
Burial | | 23b. DATE
3/7/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington F. H. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
TAPPAHANNOCK VA | | 23e. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
March F. H. EAST | | ADDRESS
1101 E. North Ave. | | 25b. REGISTRAR'S SIGNATURE
Julia D. R. R. R. | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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8 REG. NO. 07623



NEWARK ROAD



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048491 MAR 30

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 694

| | | | | | | | | | | | | | | | | | |
|---|---------|---|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|--------------|--|--------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| CHARLES | | W. | | PEARL | | | | 3-25-87 | | 3 | | 25 | | 87 | | 10AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | Apr 7 1925 | | 61 YRS. | | MONTHS | | DAYS | | 3-25-87 | | 3 | | 25 | | 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 5614 Pioneer Drive | | Ret. Postman | | U S. Gov't | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | | | Baltimore | | YES | | 5614 Pioneer Drive 21214 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Charles | | Ruie | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | 17. INFORMANT | | ADDRESS | | | | | | | |
| Yes | | 219-14-0532 | | Dora M. Buckingham | | 3870 Valley Lane | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | YES | | NO | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| P.M. | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| NOT WHILE AT WORK | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy | | 22b. DATE | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| death resulted from: Natural causes | | Mar 28 1987 | | Lakeview Memorial | | Sykesville | | Maryland | | | | | | | | | |
| Accident | | | | | | | | | | | | | | | | | |
| Suicide | | | | | | | | | | | | | | | | | |
| Homicide | | | | | | | | | | | | | | | | | |
| Undetermined manner | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | Assistant | | 3-25-87 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| Margarita A. Korell, M.D. | | 111 Penn Street | | Burial | | Mar 28 1987 | | Lakeview Memorial | | Sykesville | | Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Leonard J. Ruck, Inc. | | MAR 27 1987 | | Julia Seaton Ruck | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|---|---------------------------------------|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
ISAAC H PECKOO | | | 2a. DATE OF DEATH
MONTH 3 DAY 16 YEAR 87 | | 2b. HOUR
7A M | | | | | |
| 3. SEX
M MALE | | 4. RACE
B BLACK | | 5. DATE OF BIRTH
MONTH 01 DAY 05 YEAR 34 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
JAMAICA | | 7b. CITIZEN OF WHAT COUNTRY?
JAMAICA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST IRVING MIDDLE I LAST PECKOO | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MATILDA MIDDLE JACKSON LAST JACKSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-62-3177 | | 17. INFORMANT ADDRESS
MRS. LILIE TH PECKOO 1580 PENTWOOD RD 21239 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) PULMONARY EDEMA, POSSIBLE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/23/87 , 19_____, to 3/16/87 , 19_____, that (I) (we) lost saw the deceased alive on 3/16/87 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
P Becker | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/16/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BECKER | | | | 22e. ADDRESS
225 GREENE ST UNIVERSITY HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/22/87 | | 23c. NAME OF CEMETERY OR CREMATORY
HAMPTON COURT ST. THOMAS JAMAICA, WEST INDIES | | 23d. LOCATION
CITY OR TOWN MORANT BAY ST. THOMAS W.I. COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR
NAME LEWIS T. GWYNN ADDRESS 4517 PARK HEIGHTS AVENUE 21215 | | | | | | | | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|------------|--|--|-------------------|--|--|--------------|------------------|--|---|--|--|--------------------------|-----------------------------------|--|----------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MARY | | | MIDDLE E. | | | LAST PELLENS | | | 2a. DATE KNOWN OF DEATH ESTI-MATED | | | MONTH 3 DAY 22 YEAR 1987 | | | 2b. HOUR | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | MONTH 3 DAY 22 YEAR 1987 | | | 2d. HOUR | | |
| Female | | White | | Feb. 2, 1913 | | 73 YRS. | | | | | | | | | 12:20 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Md. | | | | USA | | | | | | | | Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | | | 2725 Walbrook Ave. | | | | | | | | Homemaker | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | |
| Md. | | | | | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 3102 Royston Ave. 21214 | | | | |
| 14. FATHER'S NAME | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | | |
| Owen F. Monahan | | | | | | | | Margarete D. - | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | |
| no | | | | | | | | 212-46-1144 | | | | Mrs. Catherine Arsenault 2022 E. 31 st. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | |
| Seizure disorder | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above; held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | |
| 22b. I certify that I took charge of the remains described above; held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | | |
| | | | | M.D. Chief | | | | 3-23-87 | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | |
| John E. Smialek, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | | |
| Burial | | | | Mar. 26, 1987 | | | | Garrison Forest Veterans | | | | Owings Mills Balto. Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | | | MAR 26 1987 | | | | [Signature] | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be brought to date.

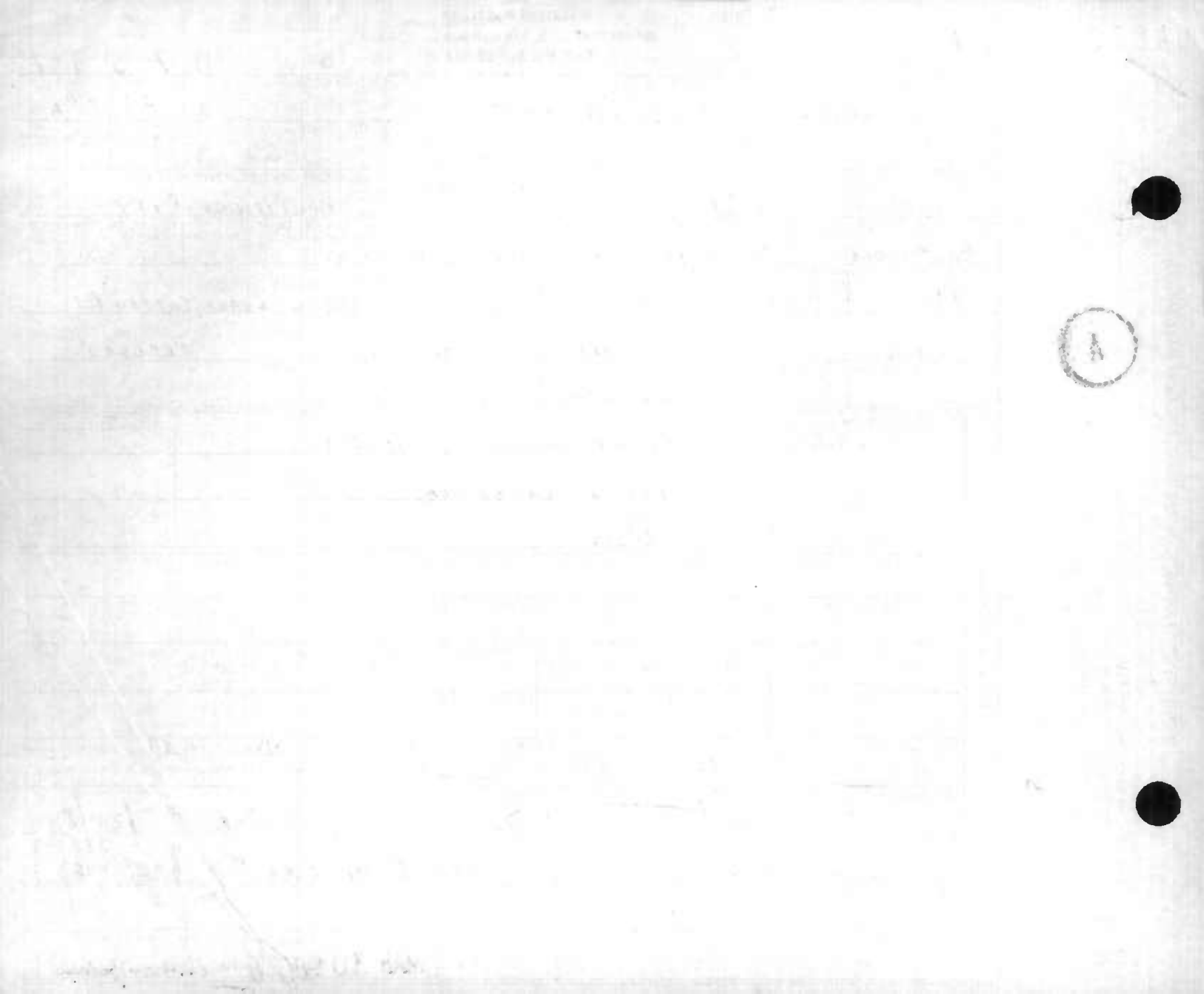
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07697

| | | | | | | | |
|---|--|---|---|--|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
JAMES N PENNINGTON | | | 2a DATE OF DEATH
MONTH DAY YEAR
3 21 87 | | | 2b HOUR
8 ³⁰ A M | |
| 3 SEX
M | | 4 RACE
B | | 5 DATE OF BIRTH
MONTH DAY YEAR
11 08 24 | | 6 AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALT GEN'L HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | |
| 12b KIND OF BUSINESS OR INDUSTRY
School | | | | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MD 13b COUNTY BALT 13c CITY OR TOWN BALT 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS / ZIP CODE 4226 EVANS CHAPEL RD. 21213 | | | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
JAMES PENNINGTON | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CAROLYN PERLEAU | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | | | 16b SOCIAL SECURITY NO.
212204966 | | 17 INFORMANT ADDRESS
Mrs. Madeline Pennington - Same as #13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ACUTE LEUKEMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) SEPSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 2/19 19 87 to 3/21 19 87, that (I) (we) lost saw the deceased alive on 3/21 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
J. A. GIRALT | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED
3/21/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
J. A. GIRALT | | 22e ADDRESS
3001 S. HANOVER #31 BALT. MD. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b DATE
3-21-87 | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION
CITY OR TOWN COUNTY STATE | |
| 24 FUNERAL DIRECTOR
NAME
State Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a DATE REC'D. BY REGISTRAR
MAR 30 1987 | |
| | | | | | | 25b REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIE PER DUE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 23 1987 | | | 2b. HOUR
12:41A M | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
3 24 1947 | | 6. AGE (IN YEARS LAST BIRTHDAY)
39 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GEN. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
POLICE OFFICER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1147 E. NORTHERN PKY. 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
MARCUS J. PERDUE | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELLAMAE MARKS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
218-44-7181 | | 17. INFORMANT ADDRESS
CHART | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Ischemic Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) Ventricular tachycardia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Hypertension Atrial Fibrillation Sarcoidosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3 13 1987 to 3 23 1987 that (I) (we) last saw the deceased alive on 3 23 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. HESAI | | | | 22e. ADDRESS
North Charles Hospital Baltimore MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
ENTOMBMENT | | 23b. DATE
3-27-87 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME
E.L. PHILLIPS | | | | ADDRESS
1721 N. MONROE STREET | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked on item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

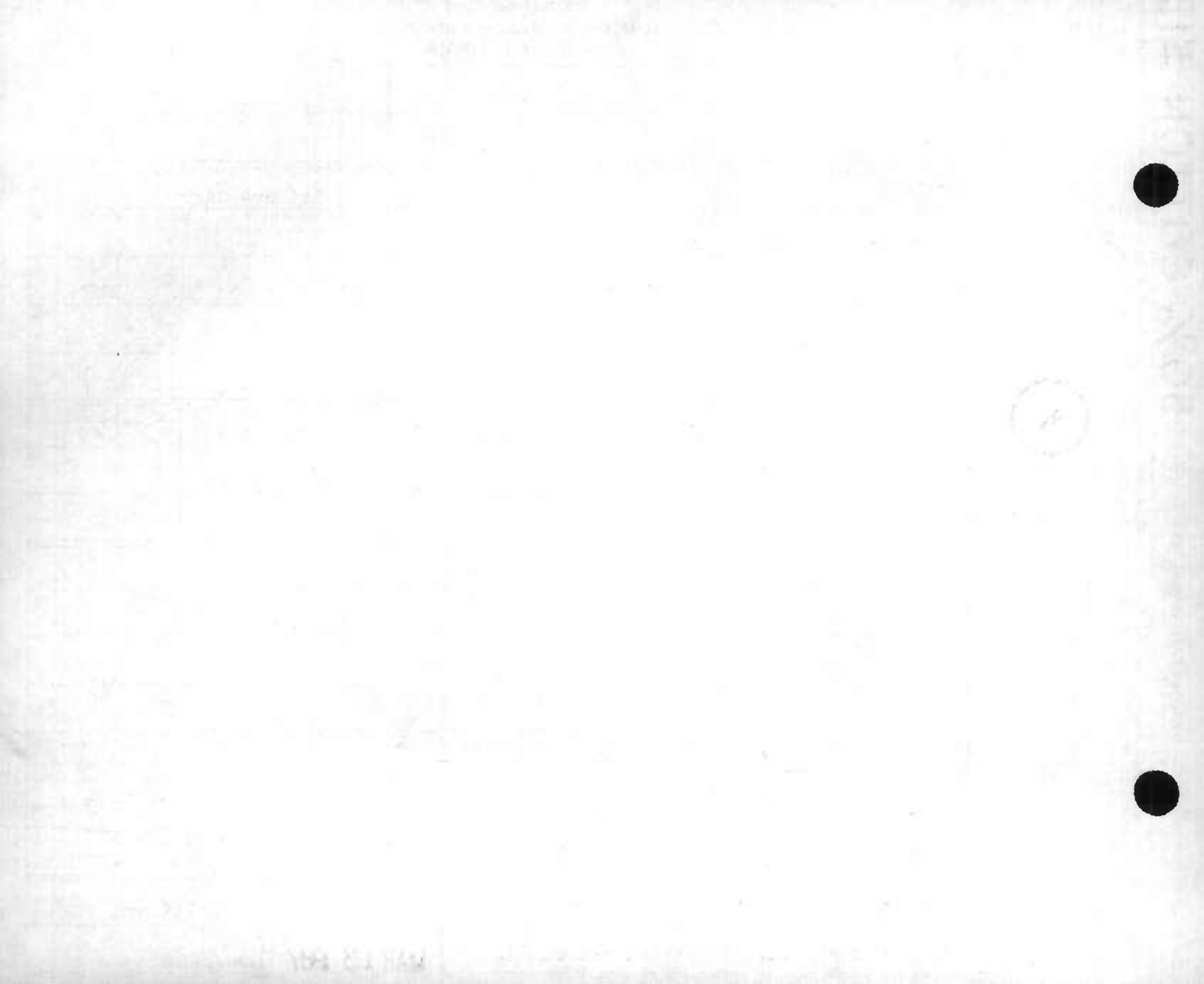
BP

DHMH-16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07699

| | | | | | |
|---|--|---|---|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| MORRIS D. PEREGOFF | | 3 2 87 | | 4 p.m. | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | |
| Male | White | 5 01 05 | 81 | Maryland | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| USA | | Baltimore City MD | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | 3903 Bartwood Rd. 21215 | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | | Baltimore City | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3903 Bartwood Rd. 21215 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| ISIDORE Peregoff | | Rose B. Unkn. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| No | | 215 01 1881 | | H. C. Bainter 3024 N. Calvert St. #E-1 21218 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19 1986</u> to <u>MARCH 2 1987</u> , that (I) (we) lost saw the deceased alive on <u>Aug 19 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| SEYMOUR H. RUBIN M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 3/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| SEYMOUR H. RUBIN M.D. | | 741 PRAIRIE HEIGHTS AVE BALTIMORE, MD 21211 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3/10/87 | | Shaarei Zion, Rosedale | |
| | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| | | | | Dundalk Baltimore MD | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Hebrew Memorial F.H. 1100 Reisterstown Rd. 21208 | | MAR 13 1987 | | Julia Davidson | |



046866 MAR

DIVISION OF VITAL RECORDS, 1101 N. PRESTON ST., BALTIMORE, MD. 21201

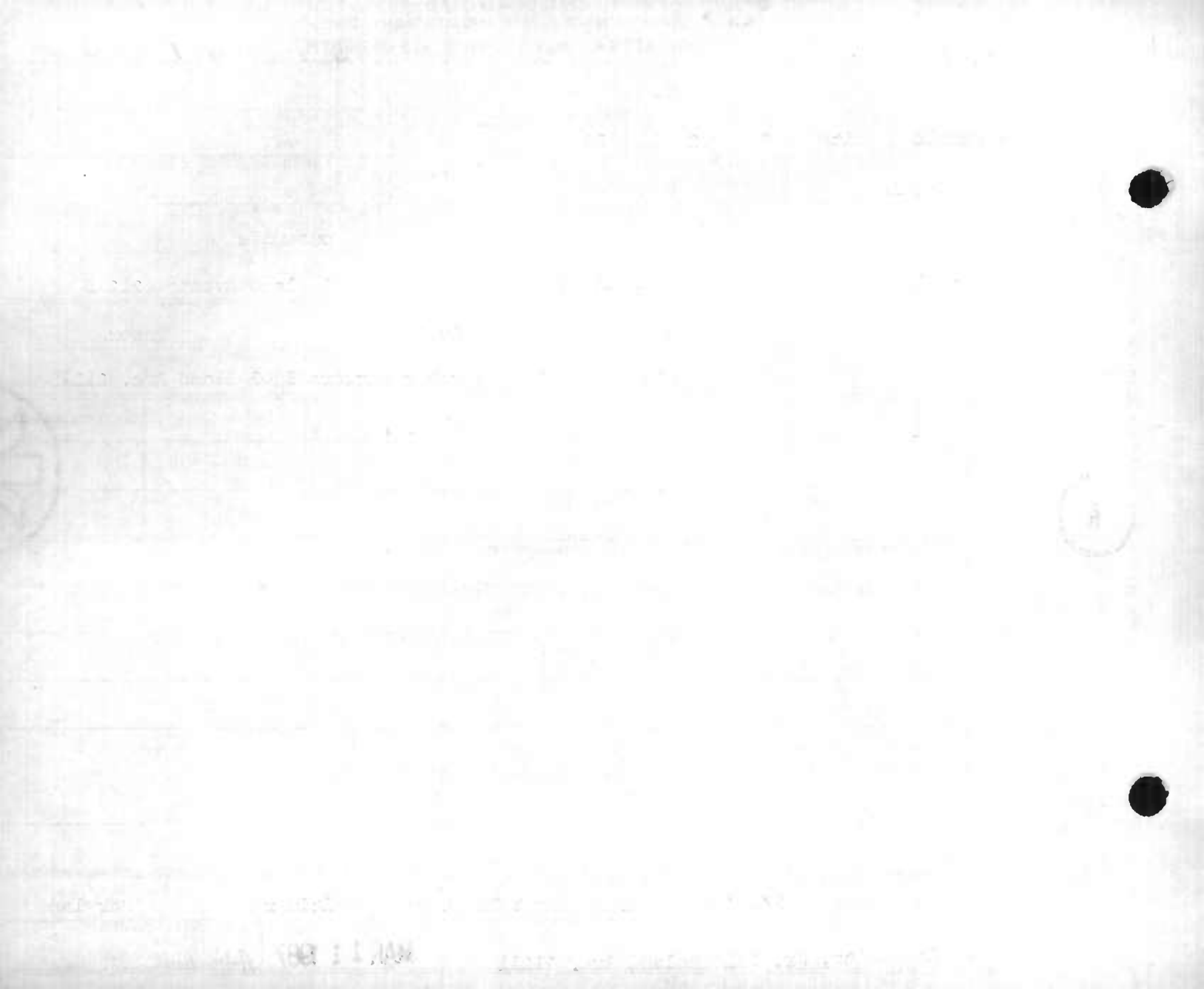
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 1101 N. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07700

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|--|--|--|---|--|---|--|--|--|---|--|-----------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Linda | | MIDDLE
C. | | LAST
Perrera | | 2a. DATE KNOWN OF DEATH
ESTIMATED
3-9-87 | | MONTH
3-9 | | DAY
19 | | YEAR
87 | | 2b. HOUR
3:15 a.m. | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 02 48 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
38 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
3-9-87 | | MONTH DAY YEAR | | 2d. HOUR
3:15 a.m. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
--- | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
5803 Bland Avenue 21215 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dewey McCann | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Ensor | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | (IF YES, GIVE WAR OR DATES)
--- | | | | 16b. SOCIAL SECURITY NO.
217-50-6586 | | | | 17. INFORMANT
Dorothy Perrera | | | | ADDRESS
5803 Bland Ave. 21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Shotgun Wound to abdomen</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4:35x 3-8 1987 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Self inflicted | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
5803 Bland Ave Baltimore MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>homicide</u> <input type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input checked="" type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Charles P. Kokes</i> | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED
3-9-87 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | | | 23b. DATE
3/10/87 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Cemetery | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz, Jr. | | | | | | | | | | | | ADDRESS
3818 Roland Ave. 21211 | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Twicken-Lundgren</i> | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the funeral director's papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (AKA) TINA MIDDLE MARIE KING
2-TINA MARIE PETERS | | | | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG. 14 1957 | | 6. AGE (IN YEARS LAST BIRTHDAY)
29 YRS | | 7b. HOUR
7:15 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3900 ELMORA AVENUE 21213 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
MD. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3900 ELMORA AVE. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM T. KING | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VIRGINIA CAVE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
218-74-9092 | | 17. INFORMANT ADDRESS
JOSEPH F. TISCHA (STEP-FATHER) SAME ADDRESS | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Recurrent Squamous carcinoma of left tongue</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 min</u>
<u>3 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>January 19 86</u> to <u>March 19 87</u> , that (i) (we) lost saw the deceased alive on <u>March 10 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ii) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Scott Kaufman</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<u>3/16/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Scott Kaufman | | | | 22e. ADDRESS
Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | |
| 24. FUNERAL HOME
SCHLUNK FUNERAL HOME, INC.
3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Julia Davis-Rodman</u> | | | | | | | | | |



048554 MAR 31 1987

FOR
STATE
REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 87702

| | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|------------------------------------|--|---|--|--------------------------------|--|---|--|---|--|--------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 2a. DATE KNOWN
OF DEATH ESTI-
MATED | | | | MONTH DAY YEAR | | | | 2b. HOUR | | | |
| LOUIS CARL PETERSON | | | | | | | | 3 14 19 87 | | | | | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE
PRONOUNCED
DEAD | | | | 2d. HOUR | | | |
| Male | | White | | 5 24 27 | | 59 YRS. | | | | | | 3 14 19 87 | | | | 8:55
A.M. | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | | | USA | | | | | | | | Baltimore City | | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | |
| Baltimore | | | | 1301 Rayleigh Way | | | | Cab Driver | | | | North Point | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS | | | |
| Maryland | | | | | | | | Baltimore | | | | xx | | | | 1301 Rayleigh Way 21224 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Louis | | | | Peterson, Sr. | | | | Mary | | | | Roden | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | | | | | 217-20-2164 | | | | Ida Shoemaker | | | | 827 Linbellen Ave. 21136 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE
SIGNED 3-14-87 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| William M. Zane, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Cremation | | | | 3-20-87 | | | | Westview Memorial Park | | | | Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Duda-Ruck Funeral Home of Dundalk
7922 Wise Ave. Dundalk, MD 21222 | | | | MAR 26 1987 | | | | John Davidson-Rendall | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

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048797 APR - 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07103

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ROSE | | FIRST
B. | | MIDDLE
PETERSON | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 30 87 | | 2b. HOUR
9²⁰ AM | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 10 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6843 Boston Ave. 21222 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Waldhauser | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Wolf | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218-09-6229 | | 17. INFORMANT ADDRESS
Leonard E. Peterson Same as 13e. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC Histiocytic NON HODGKINS Lymphoma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
Hemorrhagic cystitis, Thrombocytopenia, Anemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/26 , 19 87 , to 3/30 , 19 87 , that (I) (we) lost saw the deceased alive on 3/30 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R. Greenwell MD | | DEGREE | | 22c. DATE SIGNED
3/30/87 | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R.C. Greenwell Jr MD | | 22e. ADDRESS
Mercy Hospital, Baltimore, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Ht. of Mary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck Funeral Home of Dundalk | | 7922 Wise Ave. Dundalk MD 21222 | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LEROY PHILLIPS Sr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 17 88 | | 2b. HOUR
7:35 AM | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
8 - 7 - 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 74 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MFL Francis S. Key MC | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY
xxx AutoRepair | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY _____ 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
706 South Eaton Street 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas Phillips | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary De Lacy | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO.
217-058812 | | 17. INFORMANT ADDRESS
Mabel A. Phillips 706 S. Eaton St. 21224 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immediate |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA | | | | | | | | | 2 weeks |
| DUE TO, OR AS A CONSEQUENCE OF (c) CEREBROVASCULAR DISEASE | | | | | | | | | 8 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a Dementia; Aortic insufficiency; Left thalamic bleed, dehydration | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/13/79 , 19 79 , to 3/17 , 19 79 , that (1) (we) lost the deceased alive on 3/16 , 19 79 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE DR. Royall | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROYALL | | | | | 22e. ADDRESS
JOHNS HOPKINS Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-20-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Eastwood, Balto. Co., M d. | | | |
| 24. FUNERAL DIRECTOR NAME
Charles S. Zeiler & Son Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR
3-26-87 | | 25b. REGISTRAR'S SIGNATURE | | |



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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 07705

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------------------|---|---|---|---|--|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) RONALD A. PHOENIX | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3-18-87 | | | 2b. HOUR 6:50 PM | | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR 3 16 42 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 45 | 7. IF UNDER 1 YR.
MONTHS DAYS | 8. IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD 3-18-87 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
512 Roberts Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMP. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
512 ROBERT ST. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NORMAN JOHNSON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DEIRDRE PHOENIX | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
212420734 | | 17. INFORMANT ADDRESS
DEIRDRE WARD 1914 MCCULLOH 3rd FL 21217 | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Alcoholism
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

| | | | | |
|---|--|---|---|---|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | | |
|---|--|-------------------------------------|--|-------------------------------|
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
3-19-87 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn Street | | |

| | | | |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | 23b. DATE
3/23/87 | 23c. NAME OF CEMETERY OR CREMATORY
GREENMOUNT CEM. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Alia Tendon</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, READ INSTRUCTIONS ON REVERSE OF THIS CERTIFICATE. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

13



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07706
REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) CATHERINE E. PIERCE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 31 87 | | 2b. HOUR
MIN.
12:17 A |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 21 27 | | 6. AGE, (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
59 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles General Hospital | | 12a. USUAL OCCUPATION
(TIME OF WORK FOR MOST OF WORKING LIFE)
Retired | |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1003 Wilmot ct 21202 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles A. Scott | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hessie Williams | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
230-22-6827 | | 17. INFORMANT
ADDRESS
Christopher Pierce 2002 Homewood Ave 21202 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhagic pneumonia, bilateral, massive
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction, left ventricle
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Status post-arterial bypasses for severe peripheral vascular disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 87 , to 3/31 , 19 87 , that (I) (we) last saw the deceased alive on 3/31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. [Signature] | | DEGREE | | 22c. DATE SIGNED
3/31/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. [Signature] | | 22e. ADDRESS
2724 N. Charles St | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owens Mills md | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March 714 North Ave | | | |
| 25a. DATE REC'D BY REGISTRAR
APR - 6 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

4/10

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101-101

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07707
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|---------------|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM H. PIERCE SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-27-87 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
COL | 5. DATE OF BIRTH
MONTH DAY YEAR
11-18-14 | 6. AGE (IN YEARS LAST BIRTHDAY)
72
YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2807 BAKER ST | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | | 13b. COUNTY | | |
| 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
2807 BAKER ST 21214 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DAVID PIERCE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SUSIE FAISON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
212 059586 | | 17. INFORMANT
ADDRESS
MRS LEAH PIERCE 2807 BAKER ST 21214 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Myocardial Infarct
DUE TO, OR AS A CONSEQUENCE OF (b) APHD
DUE TO, OR AS A CONSEQUENCE OF (c) CVA
Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause: last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2/3 1981 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
2/3 | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE
114 Medical Art Bldg Baltimore CO MD | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/2/81 to 3/27/81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Robert L. Levy | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert L. Levy | | 22e. ADDRESS
114 Medical Art Bldg | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
4-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBORUS MEM PK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CO MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JOSEPH L. RUSSELL 2222 W. NORTH AVE | | | 25a. DATE REC'D. BY REGISTRAR
APR - 6 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | |

BP

4/10

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It should be removed from the certificate and taken to the funeral home for removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07708 | |
|--|--|--|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LOTIE PITKEVITS | | | | | 2a. DATE OF DEATH
MONTH 03 DAY 21 YEAR 87 | | | 2b. HOUR
9:00 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH 5 DAY 8 YEAR 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GEORGIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST Matthew MIDDLE Scoggins LAST Reed | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Reed LAST Reed | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
218-22-6659 | | 17. INFORMANT
ADDRESS
Jennette E. Catania, 109 Cornet Drive | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Organ Failure | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) SEPSIS | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Obesity + difficult vent weaning | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/23/87 , 19____, to 3/21/87 , 19____, that (I) (we) lost
saw the deceased alive on 3/21/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Stephan O Hochuli | | | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/21/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephan O Hochuli | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | | | 23d. LOCATION
CITY OR TOWN Elkridge COUNTY Howard STATE Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME Hubbard Funeral Home, Inc., ADDRESS 4107 Wilkens Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
Aria Gordon-Pedraza | | | | |

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

B

047959

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07109
REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MICHAEL E PITTS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3/14/87 | | | | 2b. HOUR
3 P.M. | |
| 3. SEX
M | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
5 2 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VA COCKERMOUTH HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Pitts | | | | 15. MOTHER'S MAIDEN NAME FIRST LAST
Catherine Alexander | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT ADDRESS
Helen L. Pitts 864 Vine St. Apt B. 21201 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) ATEAC
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
(Signature) | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. Brown | | | | 22e. ADDRESS
120608 W. North Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC)
Burial | | 23b. DATE
3/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE
OWINGS Mill, MD | | | |
| 24. FUNERAL DIRECTOR NAME
W. C. Brown | | | | 25. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | 25b. REGISTRAR'S SIGNATURE
(Signature) | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death, page 4 only, retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Their plaque remove companion pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

Q3519 NO1100 2003

Q3519 NO1100 2003

(24)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07710

| | | | | | |
|---|--|---|---|---|--|
| 1. STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| CLARENCE P POIST SR | | 03/16/87 | | 1000 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Male | White | 12 16 18 | 68 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Maryland | U.S.A. | BALTIMORE CITY MD. | | Chief of Calibration Worker | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE | |
| BALTIMORE CITY | ST. AGNES HOSPITAL | Civil | | 22 Dunmore Road 21228 | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 15. MOTHER'S MAIDEN NAME | |
| Maryland | Baltimore | Catonsville | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | Edna Sheckles | |
| 14. FATHER'S NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| Clarence B. Poist | YES | 216-07-8203 | Anne M. Poist 22 Dunmore road 21228 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Failure & Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED (WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>87</u> , to <u>3-16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3-16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Gregory S. Gordon MD</u> | | MD | | 3-16-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Gregory S. Gordon MD | | St. Agnes, Balto. Md. 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | 3/19/87 | Sacred Heart Cem. | Dundalk Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | |
| Hubbard Funeral Home, Inc. | | 21229 | MAR 18 1987 | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07 / 11

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|-----------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Anna M. Pollack | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 30, 1987 | | 2b. HOUR
5:15 p.m. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 25, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Costea | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria Not Known | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
215-34-0556 | |
| 17. INFORMANT
Shirley M. Price | | ADDRESS
302 Ilchester Ave. | | 21218 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Left Intracerebral bleed</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>High blood Pressure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Diabetes mellitus, Chronic Obstructive Pulmonary Disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 18</u> , 19 <u>87</u> , to <u>March 30</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>March 30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>John P. Serlemittos</u> | | | | DEGREE
M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John P. Serlemittos | | | | 22e. ADDRESS
Union Memorial Hospital - Baltimore Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Apr 2 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. | | | | ADDRESS
Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR
APR - 1 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodgers | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07712

| | | | | | | | |
|--|--|---|---|---|---------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
1- Samuel (STEVE) Pollack | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/3/87 | | 2b. HOUR
3:24 AM | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 15 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS.
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CANADA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALES | | 12b. KIND OF BUSINESS OR INDUSTRY
AUTO | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JACK POLLACK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA RAPPAPORT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
YES WWII-ARMY | | 16b. SOCIAL SECURITY NO.
212-12-0561 | |
| 17. INFORMANT
MR. DENNIS POLLACK | | 17. ADDRESS
5 HIGHBUTTON CT. BALTO., MD 21236 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Exsanguination
DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured abdominal aortic aneurysm.
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
3/2/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ruptured abdominal aortic aneurysm | | 20a. AUTOPSY?
NO | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Philip M. Neustadt, MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/3/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILIP M. NEUSTADT, M.D. | | 22e. ADDRESS
SINAI HOSP. - BALTO., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAR. 5, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
MOSES MONTEFIORE WOODMOOR HEBREW | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. BALTO. MD | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Bender-Rudman | |

CRASH MOTION

COAST

100

100

100

(12)

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then place the certificate in the space provided on the permit for the funeral director's use with the State Dept. of Health and Mental Hygiene prior to burial/cremation/removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.)

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8707713
REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--------------------------------|--|--------------------------------|--|--------------------------------|--|--------------------------------|--|--------------------------------|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| BENJAMIN Franklin POTTER | | | | | | | | MARCH | | | | 11 | | 1987 | | | | 12 30 PM | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | MONTHS | | DAYS | | HOURS | | MIN. | |
| Male | | White | | Feb. 9 05 | | 82 | | YRS | | | | | | | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Maryland | | USA | | | | Baltimore City | | | | | | | | | | | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | St. Agnes Hospital | | Yard Foreman | | B&O Railroad | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | | | |
| Maryland | | Baltimore | | Lansdowne | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19 Laverne Avenue, 21227 | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | |
| Philip T. Potter | | Clara M. Frey | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | --- | | 705-05-6165 | | Thelma P. Strumsky, 531 Shipley Road | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| | | Bunchogenic Carcinoma left lung | | with metastases | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (has been seen) attended the deceased from 2/24, 19 87, to 3/11, 19 87, that (I) (we) lost
saw the deceased alive on 3-11, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Joseph H Miller MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-11-87 | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Joseph H. Miller, M.D. | | 22e. ADDRESS
St. Agnes Hospital, 900 S. Caton Avenue | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| Burial | | 3/14/87 | | Meadowridge Mem. Park | | Elkridge Howard Maryland | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Hubbard Funeral Home, Inc., | | 21229
4107 Wilkens Ave. | | MAR 15 1987 | | [Signature] | | | | | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon #1, #2, and #3 and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07714
REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|-----------------------------|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILDEED POWELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 7 87 | | | 2b. HOUR
2:15 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 22 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 6. AGE (IN YEARS LAST BIRTHDAY)
IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | 13e. STREET ADDRESS / ZIP CODE
1821 N. Charles St. 21218 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-03-0440 | | 17. INFORMANT
Route 1 Box 117K
Mr. Charles W. Powell Milford, Va. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
~10 DAYS
~10 DAYS
~2 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Infected Decubiti, Diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION
3/06
3/27 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
DEbridement of sacral ulcer
DIVERTING Colostomy - for ABOVE | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/7, 19 87, to 3/7, 19 87, that (I) (we) lost saw the deceased alive on 3/7, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert C. Greenwell MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT C. Greenwell Jr MD | | | | 22e. ADDRESS
Mercy Hospital Baltimore MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
3-9-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Darden | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH 3 DAY 20 YEAR 87 | | 2b. HOUR 0845 M | |
| WILLIAM | | MINSON | | POWELL | | | | | | | |
| 3. SEX male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 5 DAY 9 YEAR 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BROKER | | 12b. KIND OF BUSINESS OR INDUSTRY INSURANCE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY OR TOWN BALTIMORE 13c. CITY OR TOWN CATONSVILLE | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 815 WINTERS LANE 21228 | | | |
| 14. FATHER'S NAME FIRST WILLIAM MIDDLE MARTIN LAST POWELL | | | | | | 15. MOTHER'S MAIDEN NAME FIRST PEARL MIDDLE JESSIE LAST MINSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 212-22-4359 | | 17. INFORMANT EVELYN S. POWELL | | | | ADDRESS SAME AS # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) cerebral ischemia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) cerebrovascular insufficiency | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular disease | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A. Maciulis | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. MACIULIS | | | | 22e. ADDRESS 5411 - Wilkerson Ave. | | | | BALTIMORE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 3/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK | | 23d. LOCATION CITY OR TOWN WOODLAWN COUNTY STATE MARYLAND | | | |
| 24. FUNERAL DIRECTOR LEON M. & RUSSELL C. WITZKE | | | | FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

8 REC. NO.

0 7 7 1 6

| | | | | | |
|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WALTER G PRELL | | | 2a. DATE OF DEATH MONTH 03 DAY 21 YEAR 87 | | 2b. HOUR 5:25 AM |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH 6 DAY 8 YEAR 1918 | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST | 12b. KIND OF BUSINESS OR INDUSTRY WESTERN ELECTRI | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN CATONSVILLE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 307 LOCUST DRIVE 21228 | | |
| 14. FATHER'S NAME FIRST HUBERT MIDDLE B. LAST PRELL | | | 15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE EMMA LAST JENKINS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW II | | 16b. SOCIAL SECURITY NO. 213-16-3985 | 17. INFORMANT ADDRESS SHARON D'ANNA 1608 KIRKWOOD ROAD BALTIMORE, MD. 21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) INFECTED SYNTHETIC AORTO GRAFT SITE
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION 2-15 3-4 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured AAA, Acalculous Cholecystitis | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 YEAR 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that the (this hospital) attended the deceased from Feb 14 19 87 , to March 21 19 87 , that the (we) last saw the deceased alive on Mar 21 19 87 , and that in (my) one opinion death occurred on the date and hour and from the causes stated above, (I) we (did) did not view the body after death. | | | | | |
| 22b. SIGNATURE Bert J. Morton DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3/21/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORTON | | 22e. ADDRESS ST. AGNES HOSPITAL, BALTIMORE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 3/24/87 | 23c. NAME OF CEMETERY OR CREMATORY WOODLAWN | | 23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE | | | 25a. DATE REC'D. BY REGISTRAR MAR 23 1987 | | |
| 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | | | |

10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10

10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10 10-10-10

048350 MAR 27

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|---------------------------|--|--|
| 1- STATE REGISTRAR | | | | | | | | | |
| 87 REG. NO. 07717 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY PRICE | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 20, 1987 | | 2b. HOUR
3:42aM | | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 4 1942 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeping | | 12b. KIND OF BUSINESS OR INDUSTRY
Quality Inn | |
| 13a. STATE
Md | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3205 Baker Street 21216 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
June Harrison | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Annie Battle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
241-64-3042 | | 17. INFORMANT ADDRESS
James Price 3205 Baker Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA OF THE LUNG
DUE TO, OR AS A CONSEQUENCE OF
(c) METASTASIS TO THE BRAIN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
PNEUMONIA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 9, 19 87 , to MARCH 20, 19 87 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 20, 19 87 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
TAWFIK CHANI | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/20/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TAWFIK CHANI | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/27/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Battlesboro Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Battlesboro N.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Avenue | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | | 25b. REGISTRAR'S SIGNATURE
Wm. Harrison-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07718

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Willie Price | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 / 22 / 87 | | | 2b. HOUR
11¹⁵ P.M. | | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 23 39 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Kitchen Helper | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21223 2606 Lauretta Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
COUS Price | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JOHNNIE GLEN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
218-38-3661 | | 17. INFORMANT
ADDRESS
Ernestine Price 2606 Lauretta Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Presumed Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Toxic Epidermal Necrolysis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 minutes
24 hours
24 days | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Chronic Hypertension | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 3 / 11 , 19 87 , to 3 / 22 , 19 87 , that (1) (we) last saw the deceased alive on 3 / 22 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/23/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Matthew L. Goodrich | | | 22e. ADDRESS
Francis Scott Key Medical Center | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3-27-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
William C. Brown 1206-08 W. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

BP



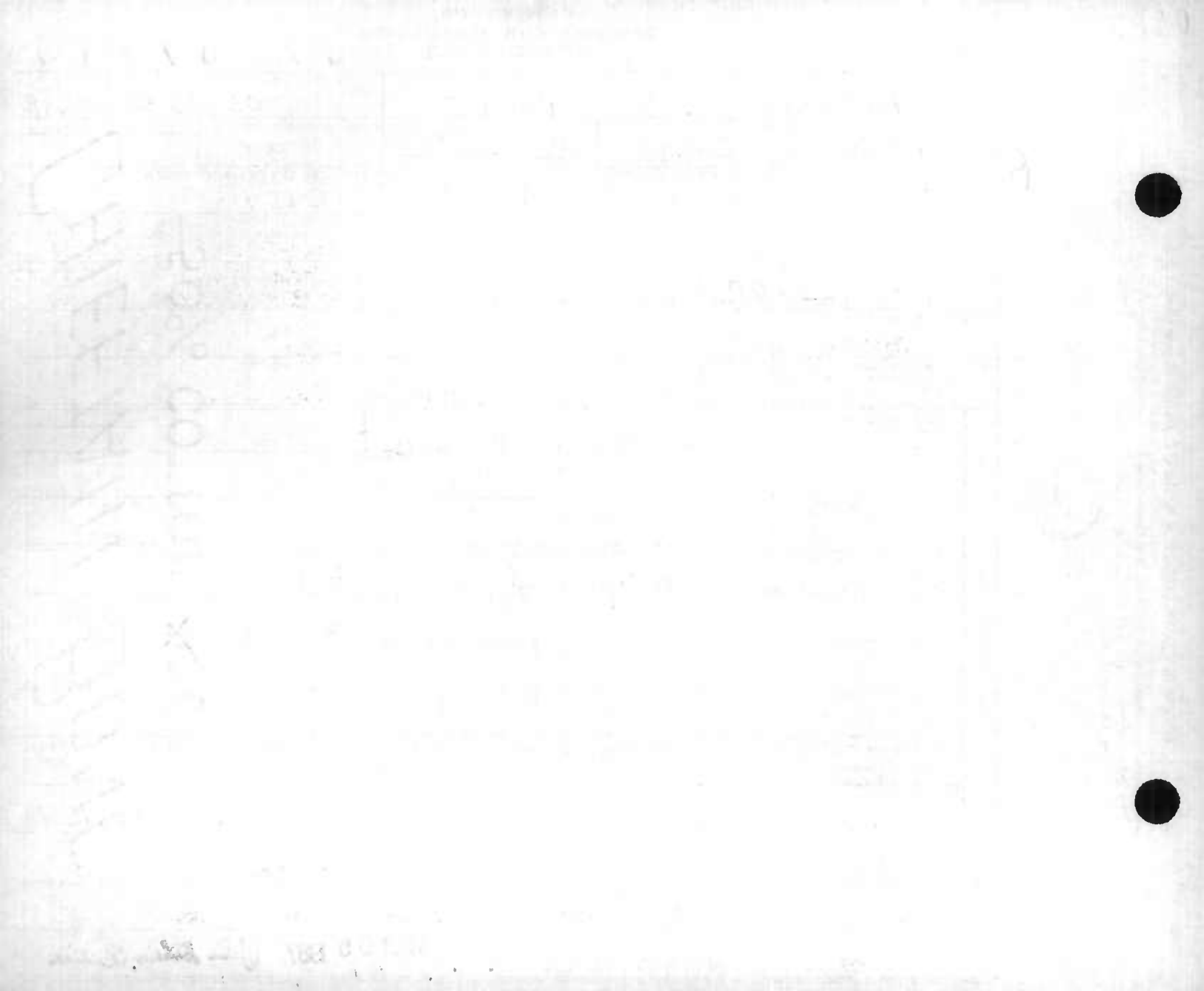
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the container with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 REG. NO. 07719 | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
FREDERICK W. PRIEBE | | | | 2a. DATE OF DEATH MONTH DAY YEAR
03-03-87 | | | | 2b. HOUR
10:43 PM | |
| 3. SEX
M Male | | 4. RACE
C White | | 5. DATE OF BIRTH
May 15 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GEN. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired-Checker | | 12b. KIND OF BUSINESS OR INDUSTRY
Associated | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE
MD | | 13c. COUNTY
BALTIMORE | | 13d. CITY OR TOWN
BALTIMORE | | 14. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 15. STREET ADDRESS OR CODE
203 Formale Avenue Transport
21061 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Julius EASED Priebe | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary DECEASED Dietrich | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
216057116 | | 17. INFORMANT
Louise Ballard, Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Carcinoma of colon with hepatic and pulmonary metastases | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3001 S. HANOVER ST. 21230 | | | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 3/3 , 19 87 , to 3/3 , 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 3/3 , 19 87 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W. Rahming | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
3/3/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAHMING | | | | 22e. ADDRESS
3001 S. HANOVER ST. 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
March 7, 87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard MD | | | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley, Glen Burnie, MD | | | | 25. DATE RECEIVED BY REGISTRAR
MAR 06 1987 | | 26. REGISTRAR'S SIGNATURE
[Signature] | | | |

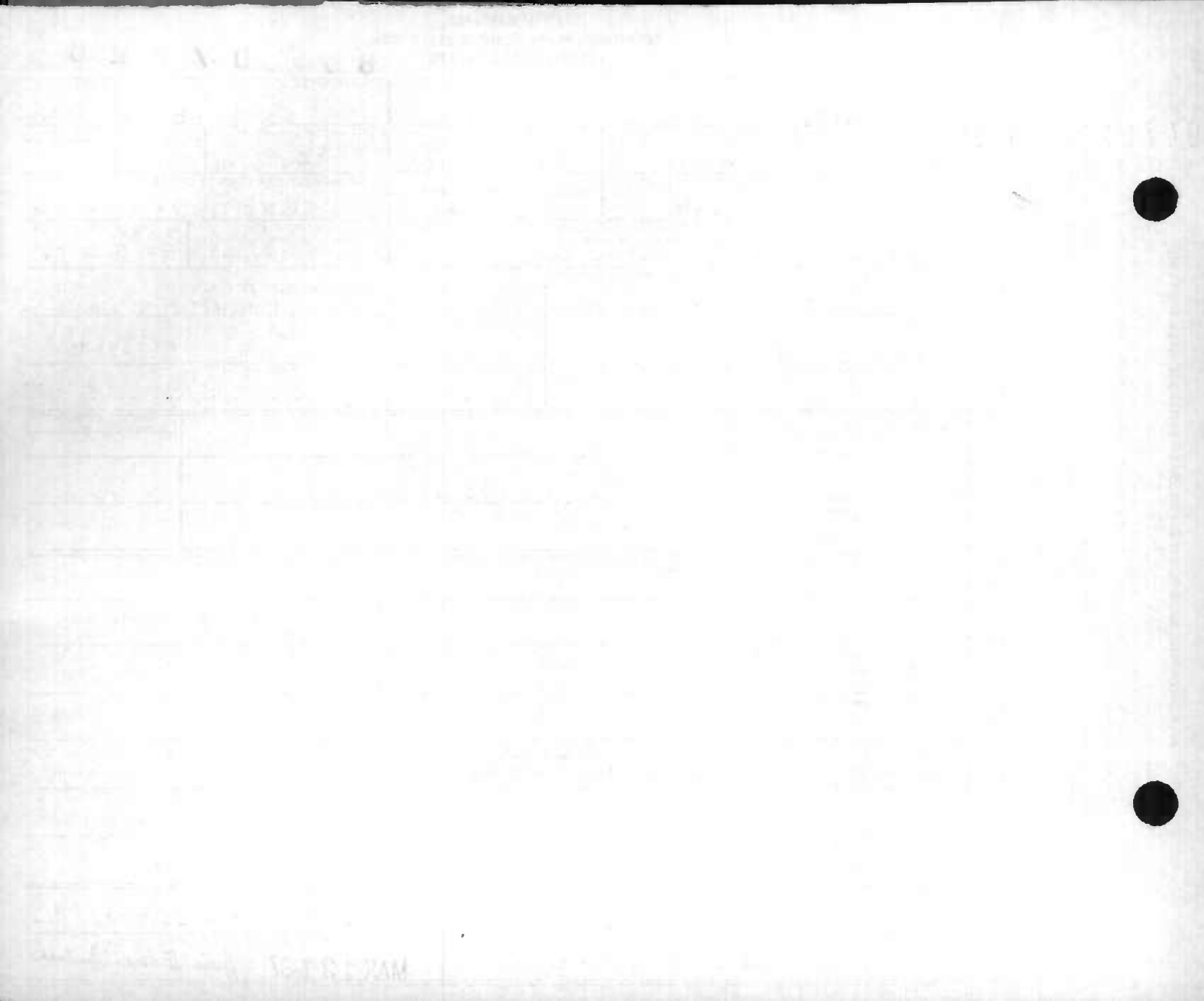


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 87 REG. NO. 07720 | |
|---|--|--|---|--|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED A MIDDLE PRINCE LAST | | | | | 2a. DATE OF DEATH MONTH 03 DAY 06 YEAR 87 | | | 2b. HOUR 5:45 AM | | | |
| 3. SEX F | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 07 DAY 21 YEAR 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Central Supply | | | 12b. KIND OF BUSINESS OR INDUSTRY Bon Secours | | |
| 13a. STATE MD | | 13b. COUNTY Baltimore City | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 203 S. HARRISON ST 21233 | | | |
| 14. FATHER'S NAME FIRST August MIDDLE F. LAST Miller | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE A. LAST Richwine | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Martin C. Prince, Jr. Sykesville, MD 21784 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/6/87, 1987, to 3/6/87, 1987, that (1) (we) last saw the deceased alive on 3/6/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE GHINWA DUMYATI | | | | | DEGREE | | | 22c. DATE SIGNED 3/6/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHINWA DUMYATI | | | | | 22e. ADDRESS GOOD SAMARITAN HOSP | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 03-10-87 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore MD | | | |
| 24. FUNERAL DIRECTOR NAME HAIGHT FUNERAL HOME SYKESVILLE, MD ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 12 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | | | |

BP



047404 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-B4
25M

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DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| LEON | | | | PROCTOR | | | | 3 | | 15 | | 1987 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| F | B | 5 1 39 | | 47 YRS. | | | | | | 3 | | 15 | | 1987 | | 8:28 A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | MD. | |
| S.C. | | USA | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 1200 N. Parrish St. | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1200 Whatcoat St. | | | | | | | | 21217 | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | |
| Hollie | | Proctor | | | | Mary | | Marion | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | Unkn | | Atlee Feaster | | 811 Mt. Holly St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Alcoholism with fatty liver | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | DATE SIGNED | | 3-15-87 | | | | | | | | | |
| ACTUAL SIGNATURE | | M.D. Assistant | | MEDICAL EXAMINER | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | William M. Zane, M.D. | | ADDRESS | | 111 Penn St., Balto., MD | | 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| Burial | | 3/18/87 | | Eastview Mem. Pk. | | Dundalk, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Wm C March F/H West | | 4300 Wabash Ave. | | | | MAR 17 1987 | | [Signature] | | | | | | | | | |

DND
MILITARY



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 07722 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROSE J PROVENZA | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 02 87 | | | 2b. HOUR
2245
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 12 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> XX | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Import | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
4906 Alson Drive Apt 101 21229 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Salvatore Provenza | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Antonina Palmisano | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-09-7997A | | 17. INFORMANT
ADDRESS
Rosina Pantaleo 1220 Canberwell Road
Catonsville, MD. 21228 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 24</u> 19 <u>87</u> to <u>MARCH 2</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>MARCH 2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Oscar C. Mendez, M.D. | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
MARCH 2, 1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
OSCAR C. MENDEZ, M.D. | | | | | 22e. ADDRESS
St. Agnes Hospital Baltimore, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/6/87 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD. | | |
| 24. FUNERAL DIRECTOR
NAME
J. & Russell C. Witzke Funeral Homes P.A.
1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 05 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return in carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 REG. NO. 07723 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 10 1987 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JASPER (JOHN) PRYOR | | | | 2b. HOUR 7:10A M | | | |
| 3 SEX M | | 4 RACE B | | 5 DATE OF BIRTH MONTH DAY YEAR 7 4 10 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BETH. STEEL | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE MD | | 13b COUNTY | | 13c CITY OR TOWN BALTO. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST UNK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK | | 13e STREET ADDRESS / ZIP CODE 1414 N. BETHEL ST. 21213 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217071174 | | 17. INFORMANT ADDRESS SHIRLEY PRYOR 925 N. ROSE STREET, 21205 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) OROPHARYNGEAL CANCER
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTE
MINUTE
MONTHS | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/28 1987 to 3/1 1987, that (I) (we) last saw the deceased alive on 3/1 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE S. B. MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3/1/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) SETH BIKAZARIAN | | 22e ADDRESS 600 N. Wolfe St. Baltimore 21205 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 3/5/87 | | 23c NAME OF CEMETERY OR CREMATORY MT. AUBURN | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE | |
| 24 FUNERAL DIRECTOR NAME MARCH FUNERAL HOME | | ADDRESS 1101 E. NORTH AVE. | | 25a DATE RECEIVED BY REGISTRAR 3/5/87 | | 25b REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

3

047459

MAR 18 1987

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07724
REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|-------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LOUIS J. PUSATERI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 13, 1987 | | 2b. HOUR
P M
7:40 | | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 3, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3208 McElderry St, 21205 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Pusateri | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Pace | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO -- | | | | 16b. SOCIAL SECURITY NO.
212-10-6482 | | 17. INFORMANT
ADDRESS
above
A. Josephine Pusateri, Wife, same as | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from March 9, 1987, to March 13, 1987, that (I) (we) lost saw the deceased on above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M.D.
ZIEGELSTEIN | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/13/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ZIEGELSTEIN | | | | 22e. ADDRESS 600 N. WOLFE ST. BALTO., MD 21205
JOHNS HOPKINS HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garden of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
SCHIMUNEK FUNERAL HOME, Balto., Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified by phone.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8707725
REG. NO. | | |
|---|--|---|---|--|---|--|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Ellen Rosella Pyles | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 28, 1987 | | | | 2b. HOUR A.
5:15 M. | | | |
| 3 SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
5/23/1901 | | 6 AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | 7a. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wesley Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6517 Cleveland Ave. 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Isaac Harpster | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
212.28.4245 | | 17. INFORMANT ADDRESS
Norman L. Hoffmann 2816 Placid Ave.
Baltimore, Maryland 21234 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
<u>Hypertension, Depression, Mild Dementia</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/11/87</u> 19 <u>87</u> , to <u>3/28</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Robert Liberto, M.D. | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
3/29/1987 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Liberto, M.D. | | | | | 22e. ADDRESS
3508 Bank St., Baltimore, Md. 21224 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/31/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Pk. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME
Walter Brooks Bradley Inc. Dundalk Md. 21222 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

24. FUNERAL DIRECTOR

Walter Brooks Bradley Inc. Dundalk Md. 21222

25a. DATE REC'D. BY REGISTRAR

MAR 30 1987

25b. REGISTRAR'S SIGNATURE

20% COTTON FIBER

1

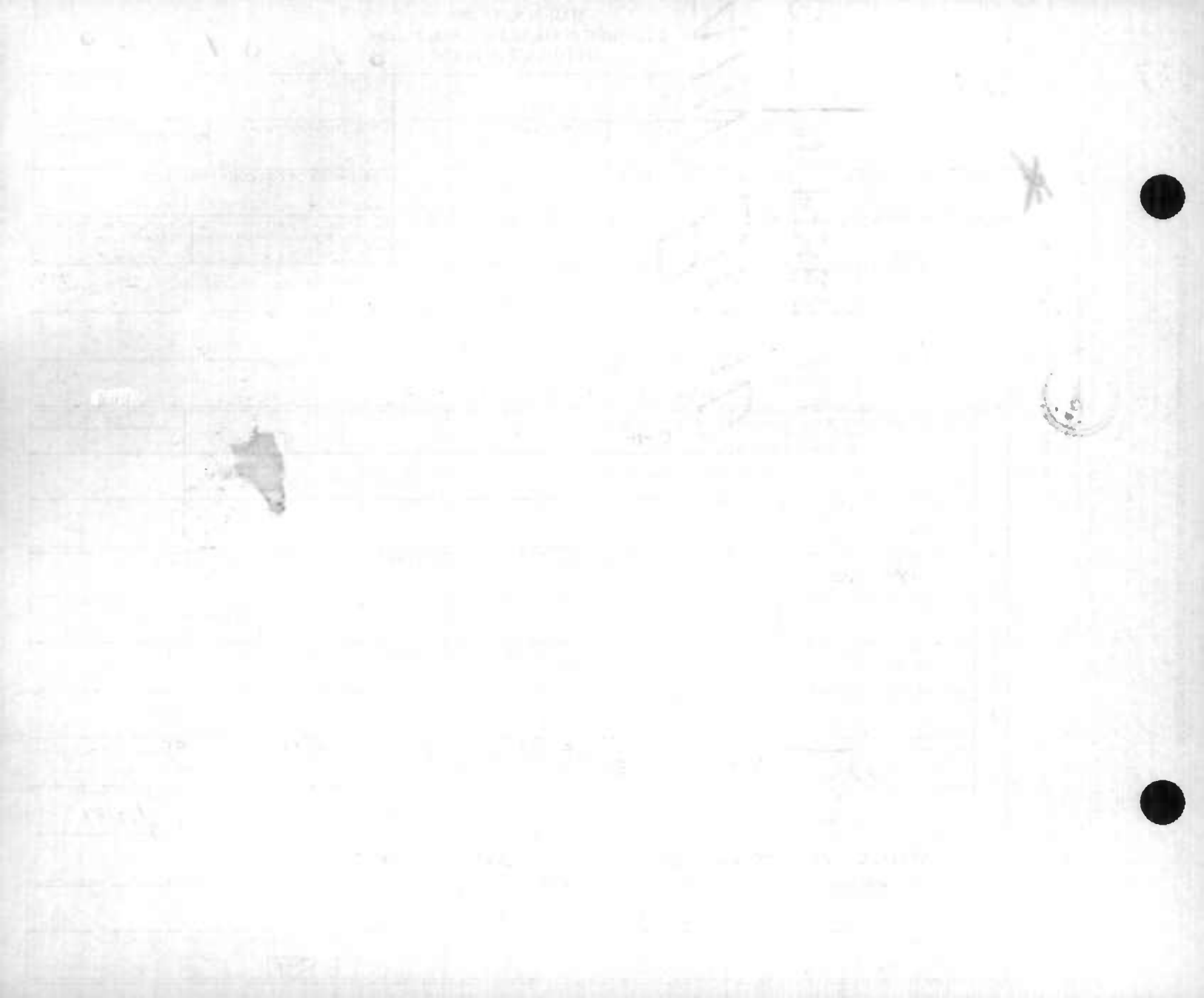
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body to another place of interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician is required to be filed at once.

| | | | | | |
|---|------------------|---|---|---|--|
| 8 M.C. # G-625, by F.H., /GBJ
FOR 3/26/87 per copy
1- STATE REGISTRAR of S.S. Card., | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 87 07126
REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Wilfred Pyne
Wilford | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 14 87 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH MONTH DAY YEAR
11 29 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
B. West Indies | | 7b. CITIZEN OF WHAT COUNTRY?
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Head Waiter | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Luncheon Club | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Pyne | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Theresa Mc Gregor | | 13c. CITY OR TOWN
Baltimore | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
053-12-9185 | | 17. INFORMANT ADDRESS
Mrs. Baltimore, Maryland
Mary E. Carter 1629 N. Fulton Ave. 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CHF
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18
187 CRF | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 2-13-1985, to 3-17-1985, that (we) lost saw the deceased alive on 3/13-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (all) did not view the body after death. | | | | | |
| 22b. SIGNATURE
 | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. N. WILSON MD | | 22e. ADDRESS
3870 FORDS LANE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/21/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | |
| 23d. LOCATION CITY OR TOWN
Baltimore | | COUNTY
Baltimore | | STATE
Maryland | |
| 24. FUNERAL DIRECTOR'S NAME
FUNERAL DIRECTOR & SONS FUNERAL HOME, INC.
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
 | |

BP



17 FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07127

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
JUANITA | | MIDDLE
Rose | | LAST
RAAFAT | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 3, 1987 | | 2b. HOUR
P
6:15 | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 17 1946 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7b. IF UNDER 24 HRS
HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Nebraska | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
Howe | | 13c. CITY OR TOWN
Columbia | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6256 Goolden Hook 21044 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Loren Greiner | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Sweet | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
481-86-7306 | | 17. INFORMANT
Naser Raafat | | ADDRESS
6256 Golden Hook | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST / SEPSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARDIOMYOPATHY</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>RADIATION THERAPY / CHEMOTHERAPY for METASTATIC BREAST CA</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Renal FAILURE</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hour | | | | | | | |
| | | | | | | | | | | 2 years | | | | | | | |
| 19a. DATE OF OPERATION
2/20/87 | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CARDIOMYOPATHY → POOR OUTPAT | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/03</u> , 19 <u>87</u> , to <u>3/3</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>3/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) see the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/3/87 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GOLDSTONE | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silersprings Md | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Avenue | | | | 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 06 1987 <u>[Signature]</u> | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been received by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then page 2 (funeral card) may be placed in the coffin with the deceased. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 is checked, or if other traumatic or violent cause of death is indicated, the body should be examined at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

A. O. F. I. C. 24
AIRMAIL 144449
DIVISION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

049161 APR

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|--------------------|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 87 07 / 28 | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ALICE KAVANAUGH RABASSA | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 28, 1987 | | 2b. HOUR
2:28 M | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
DAY MONTH YEAR
Feb. 6, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY)
84 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital, Inc. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Fed. Gov't. | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2806 E. Baltimore St. 21224 | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Eugene P. Kavanaugh | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Gribben | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213.05.1474 | | 17. INFORMANT
Mary Alice Butts | | | | ADDRESS
(Same as 13e) | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 min. | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PULMONARY CONGESTION</u> | | | | | | | | | | 5 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>RENAL FAILURE</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>COLON CANCER</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 21</u> 19 <u>87</u> , to <u>MARCH 28</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>MARCH 28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Carol S. Ramsey</u> | | | | DEGREE
D.O. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CAROL RAMSEY, D.O. | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Cremation | | 23b. DATE
3/30/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
Walter Brooks Bradley Inc. Dundalk Md. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>don Rende</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



048064 MAR 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial transit permit. The funeral director should also complete page 4 and 5 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, after traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|---|--|---|--|
| 1 - STATE REGISTRAR | | | | | REG. NO. 07729 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Bertha L. Raesler</u> | | | | | 2a. DATE OF DEATH MONTH <u>3</u> DAY <u>20</u> YEAR <u>87</u> 2b. HOUR <u>6:45 P.M.</u> | | | | | | | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>Caucasian</u> | | 5. DATE OF BIRTH MONTH <u>9</u> DAY <u>18</u> YEAR <u>03</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>POLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Factory worker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u> | | | | | |
| 13a. STATE <u>MD</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Baltimore</u> | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <u>1453 Andre ST / 21230</u> | | | | | | |
| 14. FATHER'S NAME FIRST <u>STANLEY</u> MIDDLE <u>LEWANDOWSKI</u> LAST <u>PAULINE</u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>LUDWICKI</u> MIDDLE <u>LUDWICKI</u> LAST <u>LUDWICKI</u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES) <u>—</u> | | | | | 16b. SOCIAL SECURITY NO. <u>215-24-1855A</u> | | 17. INFORMANT ADDRESS <u>21230 Bertha Raesler W 1433 Andre St</u> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.) | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>with Congestive Heart Failure</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR <u>—</u> A.M. MONTH <u>—</u> DAY <u>—</u> YEAR <u>19</u> P.M. | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/15/87</u> 19 <u>87</u> , to <u>3/20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE <u>Song Chol Chon</u> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>3/20/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SONG CHOL CHON, M.D.</u> | | | | | 22e. ADDRESS <u>3001 S. Hanover ST. Baltimore, MD 21230</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | | 23b. DATE <u>3/24/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>6515 Foster Ave. Baltimore, MD</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Choual Steven</u> | | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAR 23 1987</u> | | | | | 25b. REC'D. BY REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (see General directions, page 3), should be detached for use as the burial-transit permit. Then please submit to the funeral director, who will forward it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. 8 2 0 7 7 3 0 | |
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES RAINY | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 12, 1987 | |
| 3. SEX
MALE | | 7b. HOUR
6:52P M | |
| 4. RACE
BLACK | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
06-27-1937 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 7b. CITIZEN OF WHAT COUNTRY?
USA | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | |
| 13c. CITY OR TOWN
BAL. CITY | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HORACE EPPS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
TILLIE RAINY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
225-44-8012 | |
| 17. INFORMANT
FAMILY AND NELLIE TAYLOR | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Massive intracranial hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 min
6 days
>10 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>noncompliance with medications, alcohol abuse</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/8/87</u> , 19 <u>87</u> , to <u>2/12</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/12/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Brian LITT</u> | | 22c. DATE SIGNED
2/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRIAN LITT, MD | | 22e. ADDRESS
600 N. Wolfe St, Balto, MD 21205 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
02/16/87 | |
| 23c. NAME OF CEMETERY OR CREMATORY
FAMILY CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
VICTORIA LUNENBURG VA | |
| 24. FUNERAL DIRECTOR
NAME <u>Phillip Bell</u> ADDRESS <u>311 N Patrick St Alex VA 22314</u> | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | |
| 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | |

U.S. DEPARTMENT OF JUSTICE

VIRGINIA

300 DAY STREET

1911

1911

JOHN B. HARRIS

HARRIS BROS

RETAIL AND WHOLESALE

1911-1912

1911

1

Handwritten notes and signatures in the left margin.

Main body of the document containing faint, mostly illegible text and lines.

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR Ruby C. RAMSEY | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Ruby C Ramsey | | | 2a. DATE OF DEATH MONTH DAY YEAR
3/30/87 03 30 87 | | | 2b. HOUR
2211 M | | | |
| 3. SEX
F Female | | 4. RACE
White W | | 5. DATE OF BIRTH MONTH DAY YEAR
06 14 XXXX 27 | | 6. AGE (IN YEARS LAST BIRTHDAY)
XXXX 59 YRS | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
XXXXXXX WV | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. XXXXXX NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of MD Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Arbutus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5528 Selma Avenue / 21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Leo Greenway | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Minnie Ruth Young | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
236-40-6965 | | 17. INFORMANT ADDRESS
21227 Virginia C Evans/5528 Selma Ave/ Balto Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Metastatic Squamous Cell CA (Lungs → Brain)</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Rajni Sharma | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Rajni Sharma | | | | 22e. ADDRESS
Univ of MD Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
04/03/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crematorium | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Catonsville, Md 21228 | | | |
| 24. FUNERAL DIRECTOR NAME
Walters Funeral Home/Pratt & Stricker Streets | | | | 25a. DATE REC'D. BY REGISTRAR
APR 03 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia B. ... | | | |

BP.

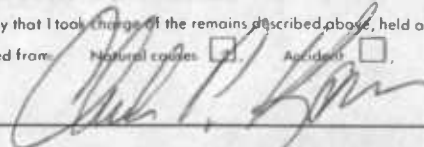


048448 MAR 31

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 07732

| | | | | | | | | | | | | | | | |
|---|--|------------------|--|---|--|--|--|---|--|---|--|---|--|----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Lewis | | MIDDLE
F. | | LAST
Ransom | | 2b. DATE KNOWN
OF DEATH
ESTI-
MATED | | <input checked="" type="checkbox"/> MONTH
3 22 87 | | 2d. HOUR
19 8:38p | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 1, 1910 | | 6. AGE (IN YEARS
LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE
PRONOUNCED
DEAD
3 22 87 | | 2d. HOUR
19 8:38p | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Balto. Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION
(FOR MOST OF WORKING LIFE)
Clergyman | | | | 12b. KIND OF BUSINESS
OR INDUSTRY
Methodist Ch. | | | |
| 13a. STATE
MD | | | | 13b. CITY OR TOWN
Baltimore | | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13d. STREET ADDRESS
21204
121 Swarthmore Dr., Towson, MD | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur R. Ransom, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie E. Norris | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | | | |
| 16b. SOCIAL SECURITY NO.
705-12-8530 | | | | 17. INFORMANT
Mrs. Sally J. Ransom, 121 Swarthmore Dr., | | | | | | | | ADDRESS
Towson, MD 21204 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot Wound of abdomen (unspecified weapon)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
? 3 22 87
P.M. | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
street | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Unit blk of South Eutaw St. Balto. City MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE
SIGNED 3-23-87 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | ADDRESS
111 Penn Street, Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
3/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Balto. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc., 6500 York Rd., | | | | ADDRESS
Balto., MD 21212 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

ORIGINAL
RECEIVED
MAR 27 1951



MAR 27 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate to Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07733

FOR
1- STATE
REGISTRAR

| | | | | | | |
|--|--|--|---|---|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William Jerome Rathell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
march 1, 1987 | | 2b. HOUR
1148 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 21, 1924 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 8. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William A. Rathell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Adler | | 16. SOCIAL SECURITY NO.
213-16-4076 | | |
| 17. INFORMANT
Lois M. Rathell | | 18. ADDRESS
5104 Harford Rd. 21214 | | | | |
| 19a. DATE OF OPERATION
2/27/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Drainage of Empyema, rib resection for Empyema & tracheostomy | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Ø | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Ø | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Ø | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 20, 1987 to March 1, 1987 , that (I) (we) lost saw the deceased alive on march 1, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Jeffrey A. Grass, M.D. | | 22c. DATE SIGNED
3/1/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey A. Grass, M.D. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Mar 5 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc. Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR
MAR 03 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Tilden-Randall | | | | | | |

148

U.S.A.



RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chapter papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | |
|---|--|---|--|---|--|---|--|
| FOR Items, #11, 13e, 17, & 6, G-626, by F.H., 4/2/87, Gbj. | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
DOROTHY V. RAWLINGS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 26 87 | | 2b. HOUR
5:20A M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
5 11 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78-77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3640 Claranell Road Clarenell | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Hayes | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Theresa Hines | | 13e. STREET ADDRESS / ZIP CODE
3640 Claranell Road 21229 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-05-8122 | | 17. INFORMANT ADDRESS
Emma Schlotthober 3640 Claranell Rd. 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>Diabetes Mellitus</i> | | | | | | | |
| 19a. DATE OF OPERATION
<i>N/A</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>N/A</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>10-24</i> , 19 <i>84</i> , to <i>3-22</i> , 19 <i>87</i> , that (1) (we) lost <i>9 MARCH</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Charles Graham</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles Graham, MD. | | 22e. ADDRESS
299 Frederick Road | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/30/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Anderson-Randall</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper tabs and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

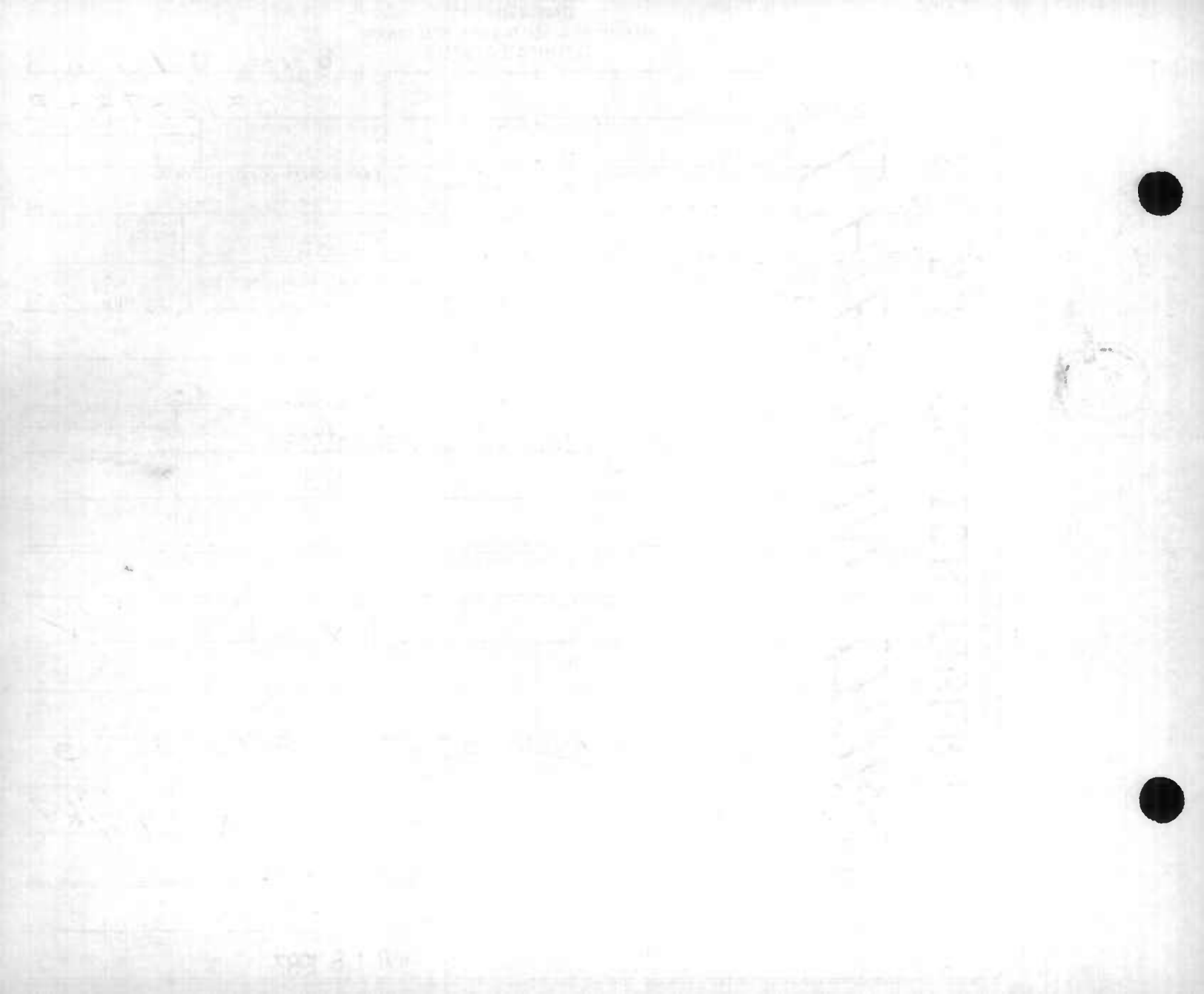
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO. 07735

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
AMANDA E. RAY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03/16/87 | | 2b. HOUR
8:34 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 6, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3039 Huntingdon Avenue 21211 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Noah H. Putman | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida May Stauffer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217 01 8001 | | 17. INFORMANT
ADDRESS
Mr. David B. Mc Ardle same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction.
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I (this hospital) attended the deceased from March 12, 1987 to Mar 16, 1987, that (I (we) last saw the deceased alive on Mar 16, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above.) (I (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Jeffrey Cool MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JEFFREY COOL | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/20/1987 | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Burgee-Henss Funeral Home, 3631 Falls Road | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07736 |
|--|--|------------------------------|--|--|--|--|---|---|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 87 |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | 47 PM |
| Alsup | | | Raymond | | | 3-13-87 | | 2 | | PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| male | | Black | | 9-9-44 | | 42 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| | | | Liberty Medical Center | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | | | | Baltimore | | | | 4124 Walrad St. 21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Raymond Alsup | | | | | Mary B Hobbs | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| | | | 215-40-8837 | | Mary Alsup 727 Druid Hill Lake Dr. 14 I | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardio-respiratory Failure | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Possible cardiomyopathy | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Acute Alcoholism Delirium Tremens | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| Amil Ubeal | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| A UBEAL | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | 3-19-87 | | Garrison For. VA CEM | | Reisterstown Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Brown and Thompson F.H. 1913 W. Baltimore Street | | | | | MAR 19 1987 | | John Gordon Rader | | | |

BP

WILEY JOHN DAVIS

20% COILION LINE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 87 REG. NO. 07737 | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| ELEANOR | | A. REBSTOCK | | 03-30-87 | | 12 | | PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | |
| FEMALE | | WHITE | | 01-15-19 | | 68 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | | U. S. A. | | | | Baltimore City | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Balto. | | Park Manor Nursing Home | | Dishwasher-St. Agnes Hosp. | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | Balto. | | Catonsville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Balto., Md. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16a. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Harry | | Rebstock | | | | 220-36-3955 | | 2907 A Dunran Rd.-Dundalk, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18a. IMMEDIATE CAUSE (a) | | 18b. DUE TO, OR AS A CONSEQUENCE OF | | 18c. DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | MASSIVE EVA | | HAS EVA | | CANCER (R) BREAST | | 20 MIN | |
| 19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | CVA & LEFT HEMIPLEGIA / SEIZURES | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (I) the hospital attended the deceased from 3-25-1987, to 3-30-1987, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. ADDRESS | | 22d. DATE SIGNED | | | | | |
| Richard Tyson | | 936 W. NORTH RD. BALTO, MD 21217-3992 | | 03/30/87 | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | | 22g. DATE REC'D. BY REGISTRAR | | 22h. REGISTRAR'S SIGNATURE | | | |
| Richard Tyson, MD. | | | | APR - 1 1987 | | Julia Davidson-Pandora | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | 4-1-87 | | Westview Cemetery | | Balto. Balto. Md. | | | |
| 24. FUNERAL DIRECTOR | | 24a. ADDRESS | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | |
| S. Trueman Schwalb | | 5151 Balto. Nat'l Pike #29 | | APR - 1 1987 | | Julia Davidson-Pandora | | | |

• 0521 09174 • 72-10000001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07138 | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Bele F Reed | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 22 87 | | 2b. HOUR
6:15AM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 12 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY)
GA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore gen Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
none H/W | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY B-C 13c. CITY OR TOWN Baltimore | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3609 HARLEM AVE 21229 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Archie Freeman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jessie Anthony | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) unknown (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO.
213266045 | | 17. INFORMANT ADDRESS
James D. Reed 3609 Harlem Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(b) cardiac arrhythmias
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute Renal Failure | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/P Nephrectomy | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert Steadman MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/22/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. STEADMAN | | | | | | 22e. ADDRESS
3001 S. Hanover St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
3/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Saints Rest Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 4300 Wabash Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 23 1987 Julia Tridion-Pulica | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The permit requires carbon copies. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows old injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 8. REG. NO. 07739 | | 20. DATE OF DEATH MONTH DAY YEAR 3-4-87 | | 2b. HOUR 10:45 P | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE REED | | 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 7 27 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laundry | | 12b. USUAL BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PARST WREGG | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA ? | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS Mae Williams 2510 Quantico Ave. 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic shock
DUE TO, OR AS A CONSEQUENCE OF (b) UTI
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Respiratory failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-23 19 87 to 3-4 19 87, that (I) (we) lost the deceased alive on 3-4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Bui T Duong | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3-4-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG | | 22e. ADDRESS LIBERTY MEDICAL CENTER | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY EASTVIEW Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD | | | |
| 24. FUNERAL DIRECTOR NAME March F/H. | | ADDRESS East 11015 North Ave | | 25a. DATE REC'D BY REGISTRAR 06 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07740

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
NEANDER REICH | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 26, 1987 | | 2b. HOUR
2:10 P M | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
APR. 2, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CONNECTICUT | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETAIL | | 12b. KIND OF BUSINESS OR INDUSTRY
MEATS |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM REICH | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
REGINA GOLD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
052-07-9194 | | 17. INFORMANT
MRS. ESTHER REICH APT. B
7234 PARK HTS. AVE. BALTO., MD 21208 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b). <u>Cardiogenic shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(c). <u>Myocardial Infarction</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>20 min.</u>
<u>24 hrs</u>
<u>36 hrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 24</u> , 19 <u>87</u> , to <u>March 26</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>March 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Hallie D. Chant</u> | | | | 22c. DATE SIGNED
<u>3/26/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Hallie DeChant</u> | | | | 22e. ADDRESS
<u>Johns Hopkins Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
MAR. 29, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH EL MEM. PARK | |
| 23d. LOCATION
RANDALLSTOWN | | 23e. BALTO. MD | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the physician or other qualified person who attended the deceased within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the death certificate and taken to the funeral home. It should be detached from the death certificate as the burial or cremation permit. Then please remove the death certificate from the death certificate and take it to the funeral home with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked as "yes", it shows any injury, or other trauma, or other cause of death.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 REG. NO. 07741
26. DATE OF DEATH MONTH DAY YEAR 3 19 87 10 AM1. DECEASED NAME FIRST MIDDLE LAST Emma P Reid
2. SEX FEMALE 3. RACE BLACK 4. DATE OF BIRTH MONTH DAY YEAR 2 7 06
5. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. 6. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA 7b. CITIZEN OF WHAT COUNTRY? U. S. A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARTAN HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE 12b. KIND OF BUSINESS OR INDUSTRY DOMESTICUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 5510 LLOYD AVE. 21162

14. FATHER'S NAME FIRST MIDDLE LAST ARMSTEAD PRICE 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MEUNDA PRICE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 212-26-3411 17. INFORMANT BOBBY FOWLKES BALTIMORE, MO. 21216 1904 LONGWOOD STREET

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 1 day
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Congestive Heart Failure 2 years
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Dis.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Stomach Adeno CA, Hypoglycemia, Hypertension

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☒ NO ☐ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)21a. INJURY OCCURRED WHILE ☐ AT WORK NO ☐ WHILE ☐ AT WORK ☐ 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Mar 13, 1987, to Mar 19, 1987, that (I) (we) lost the deceased on Mar 19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE V Chang DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE SIGNED 3/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) V Chang 22e. ADDRESS GOOD SAMARITAN HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 3/23/1987 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MARYLAND

24. FUNERAL HOME ADDRESS NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216 25. DATE REC'D BY REGISTRAR MAR 24 1987 25b. REGISTRAR'S SIGNATURE [Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your office. The death certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this form and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic etiology, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Lillie Reid | | 2a. DATE OF DEATH MONTH DAY YEAR
3 15 87 | | | | 2b. HOUR
1:44 AM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
1 12 27 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV of Md Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
DIETICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
HOSP. ROSEWOOD ST. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE md 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4015 Edmondson Ave 21229 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
LEAZER Brooks | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNIE BOYD BROOKS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-24-0549 | | 17. INFORMANT MS. BALTIMORE, MD, 21229
DELORES REID 4015 EDMONDSON AVENUE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Leukemia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/14 , 19 87 , to 3/15 , 19 87 , that (I) (we) last saw the deceased alive on 3/15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Neil Padgett MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
3/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Neil Padgett | | | | 22e. ADDRESS
225 Green St Baltimore 21211 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/21/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
ROCKY BRANCH BAPT CH. cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
KEYSVILLE, VIRGINIA | | | |
| 24. FUNERAL HOME OR ADDRESS
NUFFLEY & SONS FUNERAL HOME, INC., 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
John S. Radabaugh | | | |



049152 APR 13

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 87743

| | | | | | |
|---|-------------------------|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH PAUL RESTIVO | | | 7a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 3-25-87
MONTH DAY YEAR | | 2b. HOUR
9PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
6/26/1942 | 6. AGE (IN YEARS)
LAST (WITH DAY) YRS.
44 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3-25-87 |
| 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital STU | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Assembly worker | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Balto. Assoc. Retarded Citiz. | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
3903 Brookhill Rd. 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul S. Restivo | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Vance | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220.42.9556 | | 17. INFORMANT
Charles D. Restivo 21146
354 Faircastle Ave. Severna Pk., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Head injury
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8PM P.M. 3-25-87 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
pedestrian struck by an auto | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Reisterstown Rd. & Old Milford Mill Rd. Balto. Co. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Maryland | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
3-26-87 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
3/30/1987 | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. |
| 24. FUNERAL DIRECTOR
Walter Brooks Bradley Inc., Dundalk Md. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM RW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

DAVID M. HAYWARD

DAVID M. HAYWARD

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST
JOHN Thomas REYNOLDS | | MONTH DAY YEAR
03 13 87 | |
| 3. SEX
Male | | 2b. HOUR
6:43 am | |
| 4. RACE
Caucasian | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
June 11, 1902 | | 84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD | |
| 7b. CITIZEN OF WHAT COUNTRY?
USA | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Policeman | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. City | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 13a. STREET ADDRESS / ZIP CODE
3225 Ramona Ave, 21213 | |
| 13a. STATE
Maryland | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13c. CITY OR TOWN
Baltimore | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Reynolds | |
| 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Gannon | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO -- | |
| 16b. SOCIAL SECURITY NO.
217-40-5675-A | | 17. INFORMANT ADDRESS
above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Hydrocephalus</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Intracerebral Hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Aspiration Pneumonia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
2 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | |
| 19a. DATE OF OPERATION
3/10/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intracerebral Hemorrhage | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 9</u> 19 <u>87</u> , to <u>March 13</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Stacy O. Ross, M.D. | | 22c. DATE SIGNED
3/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STACY ROSS, M.D. | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/16/87 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto, Md. | |
| 24. FUNERAL DIRECTOR NAME
SCHIMUNEK FUNERAL HOME, Balto, Md. 21211 | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained by the funeral director. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ESTELL G. RICE | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 9 87 | | 2b. HOUR
6:50 PM | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
09 09 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balt. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3800 W. Belvedere Ave. 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Belton Gipson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Julia Ann Gipson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
215-22-7234 | | 17. INFORMANT ADDRESS
Clotelle Jones 3684 Forest Hill Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intra cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/7/87, 19 87, to 3/9, 19 87, that (I) (we) last saw the deceased alive on 3/9, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R. Keren MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/9/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. KEREN MD | | | | 22e. ADDRESS
SINAI HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Entombment | | 23b. DATE
3/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 23d. LOCATION
Arbutus B.C. Md. STATE | | | |
| 24. FUNERAL DIRECTOR
Charles A. Rice FSPA 1300 Eutaw Pl, | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Darden | | | |

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|-------------------------|---|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Frank J. Rice | | | | | 20. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
3-1-87 | | | | | | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 21 32 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
54 YRS. | | 7. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.
11:4 P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1435 N. Bond St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Rice | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Arelee Mactill | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | |
| 16b. SOCIAL SECURITY NO.
250-46-0779 | | | 17. INFORMANT
ADDRESS
01a Rice 1435 N Bond Street | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fatty Liver
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Chronic ethanolism
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I have examined the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles P. Kokes | | | TITLE (SPECIFY)
Assistant | | | MEDICAL EXAMINER
DATE
3-2-87 | | | SIGNED | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Charles P. Kokes, M.D. | | | ADDRESS
111 Penn St., Baltimore, MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/7/87 | | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C March F/H 1101 E. North Avenue | | | | | | 25a. DATE RECEIVED BY REGISTRAR
MAR 06 1987 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |



048454 MAR 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07747 | |
|---|-------------------------|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Ruth M. RICH</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 11 87</i> | | 2b. HOUR
<i>845 PM</i> |
| 3. SEX
<i>FEMALE</i> | 4. RACE
<i>WHITE</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>6 27 99</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>87</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>NEW YORK</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE CITY</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>BALTIMORE CITY</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Shock Trauma</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | |
| 13a. STATE
<i>PA.</i> | | 13b. CITY OR TOWN
<i>FAYETTEBELL</i> | | 13c. STREET ADDRESS / ZIP CODE
<i>213 WILKINSON LANE 99994</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>FRANK VANDINE</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>MABLE SAGE</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>UNKNOWN</i> | | 16b. SOCIAL SECURITY NO.
<i>122-01-0170</i> | | 17. INFORMANT
ADDRESS
<i>VIVAN MASON 213 FAYETTEBELL, PA.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiopulmonary collapse</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction, Hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION
<i>11/6/83</i>
<i>3/13/87</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>myocardial infarction</i>
<i>hydrocephalus</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>H. Zerebet</i> | | DEGREE
<i>M.D.</i> | | 22c. DATE SIGNED
<i>3/11/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>H. Zerebet</i> | | 22e. ADDRESS
<i>22 S. Greene St. Balt MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>3-13-1987</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>SCHWARTZBETSTOWN</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>SCHWARTZBETSTOWN PA</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 27 1987</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Eline Funeral Home</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Dandora-Randall</i> | | | |

BP

PHM - 16 60M 7/84
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANCIS J. RICHARDS | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 18, 1987 | | 2b. HOUR
1:45 PM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
03 11 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
LOCAL GOVT. |
| 13a. STATE
MARYLAND | | 13b. COUNTY
21239 | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANCIS J. RICHARDS, SR. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MYRTLE PICKETT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. II | | 17. INFORMANT ADDRESS
EMILY RICHARDS 1300 GITTINGS AVE 21239 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Stroke
DUE TO, OR AS A CONSEQUENCE OF
(c) hypoxia 2° to Acute Myocardial Infarction | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Aspiration Pneumonia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 3-10 , 19 87 , to 3-18 , 19 87 , that (1) (we) last saw the deceased alive on 3-18 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
D. Hooper, M.D. | | DEGREE | | 22c. DATE SIGNED
3-18-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. Hooper, M.D. | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MARCH 21, '87 | | 23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE CEMETERY | |
| 23d. LOCATION
(CITY OR TOWN)
BALTIMORE CO., MD | | 23e. DATE REC'D. BY REGISTRAR
MAR 19 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM E. JOHNSON | | 25a. DATE REC'D. BY REGISTRAR
MAR 19 1987 | | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | 25c. REGISTRAR'S NAME
[Name] | | | |

BP

STANDARD TIME

172

WHEAT IN BOAT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 3 from this certificate, page 3, and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

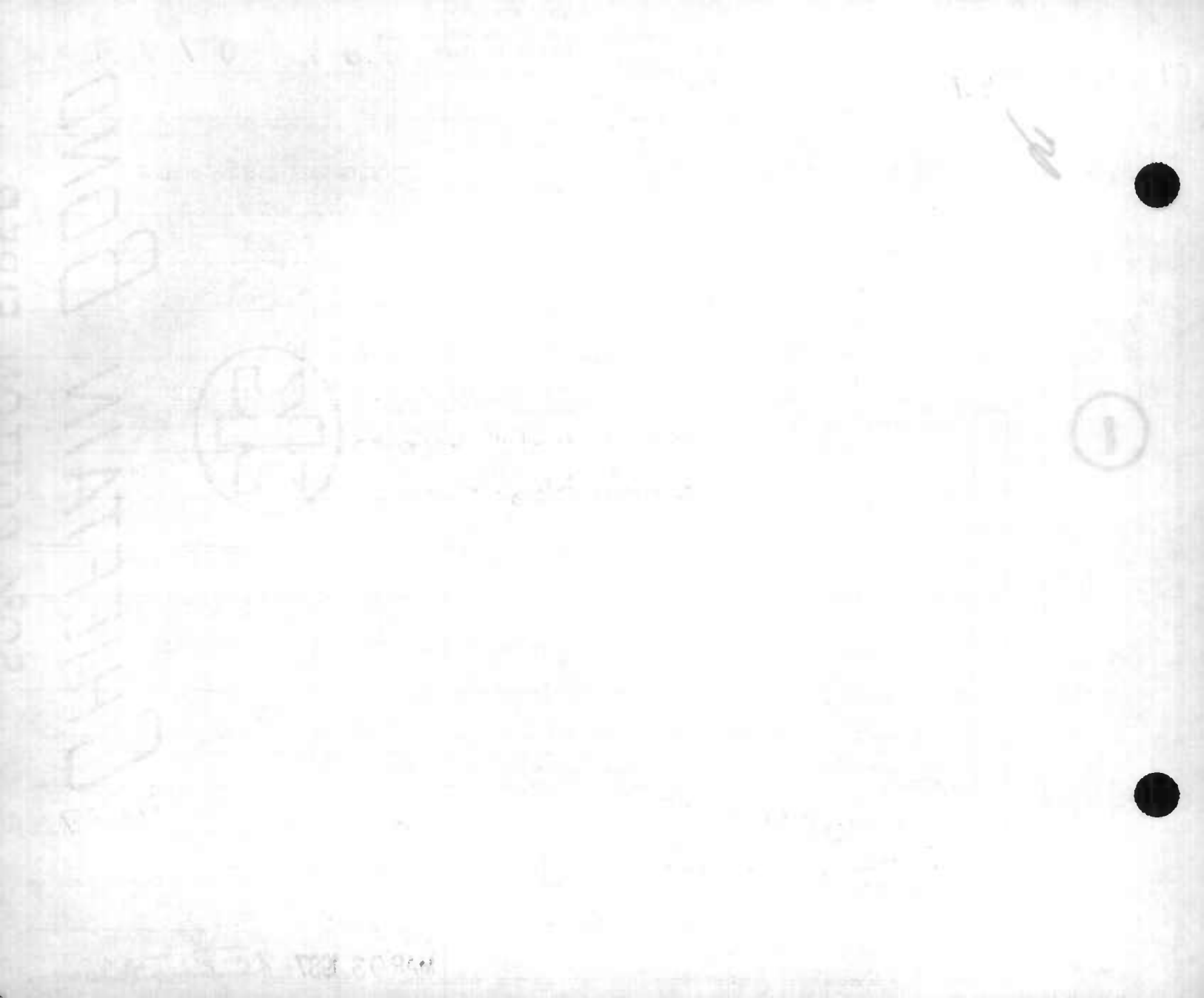
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07749

| | | | | | |
|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Eugene J. Richardson | | 3/2/87 | | 12:00 Noon | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
2/17/17 | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 8b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN NURSING HOME, GIVE STREET ADDRESS)
3922 Kenyon Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cab Owner | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Emp. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY
- | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3922 Kenyon Ave. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Richardson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa Williams | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 213-10-4263 | | 17. INFORMANT
ADDRESS
Michael J. Richardson, 3208 E. North- | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Jeffrey A. Quam</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/3/87 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey Quam | | 22e. ADDRESS
North Charles General | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 03 1987 | | | |
| 24. FUNERAL DIRECTOR
Name
Salimunek Funeral Home, Inc.
Address
3331 Brehms Lane, Balto., Md. 21213 | | 25b. REGISTRAR'S SIGNATURE
<u>John R. ...</u> | | | |

BP



049445 AP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it must be taken to the Health Department. The funeral director will receive a license to remove the body from the home within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
87 REG. NO. 07750 | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| I. DECEASED NAME
<small>(TYPE OR PRINT)</small>
<div style="display: flex; justify-content: space-between;">FIRSTMIDDLELAST</div> <p style="margin-top: 10px;">MAGGIE RICHARDSON</p> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<p style="margin-top: 10px;">MARCH 30, 1987</p> | | | 2b. HOUR
<p style="margin-top: 10px;">3:45a M.</p> | |
| 3. SEX
<p style="margin-top: 10px;">FEMALE</p> | | 4. RACE
<p style="margin-top: 10px;">BLACK</p> | | 5. DATE OF BIRTH
<small>MONTH DAY YEAR</small>
<p style="margin-top: 10px;">2 15 14</p> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<div style="display: flex; align-items: center;"> YRS <div style="display: flex; justify-content: space-between; width: 100px;"> <small>IF UNDER 1 YEAR</small>
MONTHS DAYS </div> <div style="display: flex; justify-content: space-between; width: 100px;"> <small>IF UNDER 24 HRS.</small>
HOURS MIN. </div> </div> <p style="margin-top: 10px;">63</p> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<p style="margin-top: 10px;">S.C.</p> | | 7b. CITIZEN OF WHAT COUNTRY?
<p style="margin-top: 10px;">USA</p> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<p style="margin-top: 10px;">Baltimore City MD.</p> | | | |
| 10. CITY OR TOWN OF DEATH
<p style="margin-top: 10px;">Baltimore</p> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
<small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>
<p style="margin-top: 10px;">Maryland General Hospital</p> | | | | 12a. USUAL OCCUPATION
<small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small>
<p style="margin-top: 10px;">RETIRED</p> | | 12b. KIND OF BUSINESS OR INDUSTRY
 | |
| 13a. STATE
<p style="margin-top: 10px;">MD</p> | | 13b. COUNTY
 | | 13c. CITY OR TOWN
<p style="margin-top: 10px;">BALTO.</p> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<p style="margin-top: 10px;">2 N. WASHINGTON ST. 21231</p> | |
| 14. FATHER'S NAME
<div style="display: flex; justify-content: space-between;">FIRSTMIDDLELAST</div> <p style="margin-top: 10px;">AUGUSTA BELLAMY</p> | | | | 15. MOTHER'S MAIDEN NAME
<div style="display: flex; justify-content: space-between;">FIRSTMIDDLELAST</div> <p style="margin-top: 10px;">SUSIE HENDERSON</p> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
<small>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)</small>
<p style="margin-top: 10px;">NO</p> | | 16b. SOCIAL SECURITY NO.
<p style="margin-top: 10px;">212224607</p> | | 17. INFORMANT ADDRESS
<p style="margin-top: 10px;">WILLIAM RICHARDSON 2 N. WASHINGTON ST. 21231</p> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema - Respiratory Failure</u>

DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Renal Failure, Sepsis</u>

DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<p style="text-align: right; margin-right: 50px;">15 days</p> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
<small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<p style="margin-top: 10px;">P.M. 19</p> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
OR NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
<small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from <u>March 6,</u> 19 <u>87</u> , to <u>March 30,</u> 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 30,</u> 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (we) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>M. J. AMAN</u> | | | | | | 22e. ADDRESS
<u>c/o Maryland General Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<p style="margin-top: 10px;">BURIAL</p> | | 23b. DATE
<p style="margin-top: 10px;">4/4/87</p> | | 23c. NAME OF CEMETERY OR CREMATORY
<p style="margin-top: 10px;">EASTVIEW CEM.</p> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<p style="margin-top: 10px;">BALTIMORE, MD</p> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<p style="margin-top: 10px;">MARCH FUNERAL HOME 1101 E. NORTH AVE.</p> | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<p style="margin-top: 10px; text-align: center;">APR - 2 1987 </p> | | | |

4/9



047554

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07751

| | | | | | | | | | |
|--|------------------|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
1. (Rose) J. ROSIE | | FIRST
M. | | LAST
RIGGS | | 2. DATE KNOWN OF DEATH
ESTIMATED
<input checked="" type="checkbox"/> MONTH DAY YEAR
3 14 1987 | | 2b. HOUR
M
1:45
A | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
5 13 36 | 6. AGE (IN YEARS)
LAST BIRTHDAY
50 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3 14 1987 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21217
636 N. Fremont Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elzie Riggs | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Copeland | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-32-4850 | | 17. INFORMANT ADDRESS
Janice Randall 969 North Mill Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Obesity | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
3-14-87 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
William M. Zane, M.D. | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/20/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Chatman-Harris FH 1701 McCulloh Street | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (1))

NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HENRY THOMAS RILEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
FRIDAY, MAR. 13, 1987 | | | | |
| 3. SEX
MALE | | | | | 4. RACE
BLACK | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR
MAR. 21, 1905 | | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | | | | 7b. CITIZEN OF WHAT COUNTRY?
US of A | | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3804 CRANSTON AVENUE | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
SPARROWS PT. | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | | 13b. COUNTY
BALTIMORE | | | | |
| 13c. CITY OR TOWN
BALTIMORE | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS / ZIP CODE
3804 CRANSTON AVENUE 21229 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
THOMAS RILEY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
NANNIE STROUD | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
241 03 9253 | | | | |
| 17. INFORMANT ADDRESS
MRS. HILDA V. RILEY 3804 CRANSTON AVENUE 21229 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Reported by wife "shortness of breath"</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>or pulmonary embolism</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>June</u> , 19 <u>86</u> , to <u>March 9</u> , 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>3/9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
M.O. Annous | | | | | 22c. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mohammed Annous | | | | | 22e. ADDRESS
1700. E. Northern Parkway | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | | 23b. DATE
3/19/87 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE (BALTO.) MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME
LEWIS T. GWYNN | | | | | 25. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | | | |
| 4517 PARK HEIGHTS AVENUE | | | | | 25a. REGISTRAR'S SIGNATURE
[Signature] | | | | |

MEDICAL CERTIFICATION

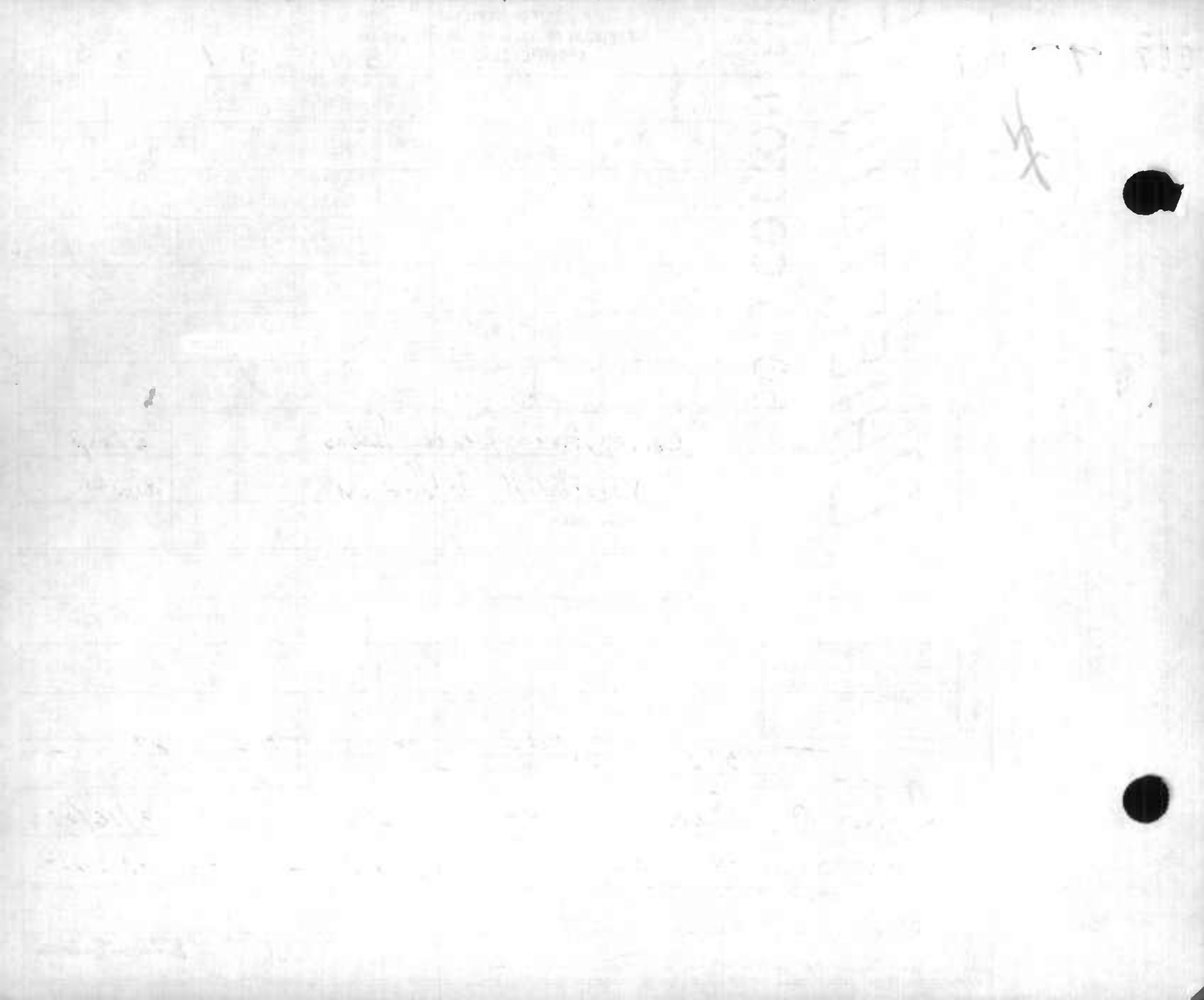
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy page 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Katherine A. Riley | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 15, 1987 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1-6-1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Med. Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Saleslady | | 12b. KIND OF BUSINESS OR INDUSTRY
Hochild Kohn & Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
8108 Bletzer Road-21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Lightner | | | | 15. MOTHER'S MAIDEN NAME
FIRST LAST
Mary Ellen Birmingham | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
216-28-1383 | | 17. INFORMANT
ADDRESS
June A. Knight - 36 Lyndale Ave.-21236 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
minutes | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 4/12 , 19 76 , to 3/2 , 19 87 , that (I) (we) last saw the deceased alive on 3/2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Louis O. Olsen | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Louis O. Olsen MD | | | | 22e. ADDRESS
1012 OLD N. Pk. - BALD. Md 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-18-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller, Inc.-6415 Belair Road-21206 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Dindern-Randner | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this death certificate must be retained at the funeral home.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07754
REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|--|--|--------------------|--|
| FOR
1 - STATE
REGISTRAR | | DECEASED NAME
(TYPE OR PRINT) | | FIRST
Robert | | MIDDLE
M. | | LAST
Riley | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 3 14 87 | | 2b. HOUR
6:50 M | |
| 3. SEX
male | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 10 04 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 72 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mt. Vernon Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
432 Burwood Ave. (21061) | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Riley | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary yeager | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. II 212-16-4016 | | 17. INFORMANT
ADDRESS
Glen Burnie
Elizabeth Gauger 432 Burwood Ave | | | | | | | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | |
| | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Ruben Reider M.D.</u> | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/27/87 | | 23c. NAME OF CEMETERY OR CREMATORY
State Veterans Cemetery | | 23d. LOCATION
CITY OR TOWN
Crownsville | | COUNTY
A.A. STATE
119 21061 | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | ADDRESS
4001 Ritchie Hwy Balto Md. | | 25a. DATE RECEIVED BY REGISTRAR
MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

048975 APR

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. These pages must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | 2a DATE OF DEATH | | MONTH DAY YEAR | | 2b HOUR | | REG. NO. 07155 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 26 DATE OF DEATH | | MONTH DAY YEAR | | 2b HOUR | |
| ANGELO RIZZO | | | | 3 17 87 | | 6 PM | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| Male | | White | | 10 16 87 | | 77 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD. | | USA | | | | BALT. CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALT. | | MERCY | | Tailor | | Tailor | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | |
| MD. | | | | BALT. | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e STREET ADDRESS | | ZIP CODE | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 219 S. HIGH ST | | 21202 | | | |
| GENNARO RIZZO | | MARIA LANDALFI | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | |
| Yes | | ARMY NVA 213-03-3877 | | MARIA RIZZO | | 219 S HIGH ST. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | Pneumonia | | Multiple myeloma | | | | 3 Days | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | 2 years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| History of UPPER Gastrointestinal Bleed; Granulocytopenia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12 19 87, to 3/17 19 87, that (I) (we) last saw the deceased alive on 3/12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Robert C. Greenwell MD | | MD | | | | 3/17/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| ROBERT C. Greenwell MD | | 301 ST. Paul Pl. BALT. MD | | Mercy Hosp. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 3/21/87 | | Holy Redeemer | | Balt. MD. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| James J. ... | | 321 S. High St | | MAR 26 1987 | | Julia Davidson-Radach | | | |

2/21/87 H. W. R. - max R
MAR 20 1987

2M5K

7/2/21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 8 7 REG. NO. 0 7 7 5 6 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Ella Louise Robbins | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 23 1987 | | 2b. HOUR M | | | |
| 3 SEX female | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 17 27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2034 E. Fayette Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOTEL WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md COUNTY ... | | | | 13b. CITY OR TOWN Baltimore | | 13c. STREET ADDRESS / ZIP CODE 2034 E. Fayette Street 21231 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WESLEY POWELL | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AISLEY PULLMAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 246202031 | | 17. INFORMANT ADDRESS WILLIE J. ROBBINS, SR. 2034 E. FAYETT 21231 | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Active Hepatitis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ... | | | | | | | | | |
| 19a. DATE OF OPERATION 2/9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 78 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-30 19 78 to 2-5 19 87 and that (I) (we) lost saw the deceased on 2-5-87 19 ... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE Aldo Paz MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 3-26-87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aldo Paz | | | | 22e. ADDRESS 1000 E. Eager St. - Balto - 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/30/87 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Bender-Rudolph | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / REG. NO. 07151

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William E. Robbins | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 29, 1987 | | 2b. HOUR
MIN.
2 P M | |
| 3 SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
September 28 1909 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Balto | | 12b. KIND OF BUSINESS OR INDUSTRY
Gas & Electric | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Lochearn | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS (ZIP CODE)
6602 Laurel Dr. | | 21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William A. Robbins | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-05-4568 | | 17. INFORMANT
NAME ADDRESS
Mrs. Lorraine E. Jones
CO 1514 Woodridge Lane Sykesville | | 21784 Maryland | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiac arrhythmia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Gangrene of leg**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Chronic organic brain syndrome

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/29 , 19 87 , to 3/29 , 19 87 , that (I) (we) last saw the deceased alive on 3/29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (she) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Moses Schreman | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Moses Schreman | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-1-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Eldersburg Carroll Maryland | |
| 24. FUNERAL DIRECTOR
Loring Byers Funeral Directors, Inc.
ADDRESS
8728 Liberty Road Randallstown, Maryland 21133 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove transit papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07758 | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Blanche R. Robinson | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 6, 1987 | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
August 2, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Greenwood Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2710 W. Franklin Street 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph C. Perry | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie V. Linton | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | |
| 16b. SOCIAL SECURITY NO.
212-24-8686 | | 17. INFORMANT
ADDRESS
Forest Hill, Md.
Virginia L. Brooks 328 Montgomery Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARRHYTHMIAS
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
ACVA - M. Fibriillation | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-5-19-87 to 3-6-19-87 that (I) (we) last saw the deceased alive on 3-6-19-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mohammad Aslam M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mohammad Aslam MD | | | | 22e. ADDRESS
Md. Gen. Hospital Baltimore, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar. 10, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 09 1987 | | | |

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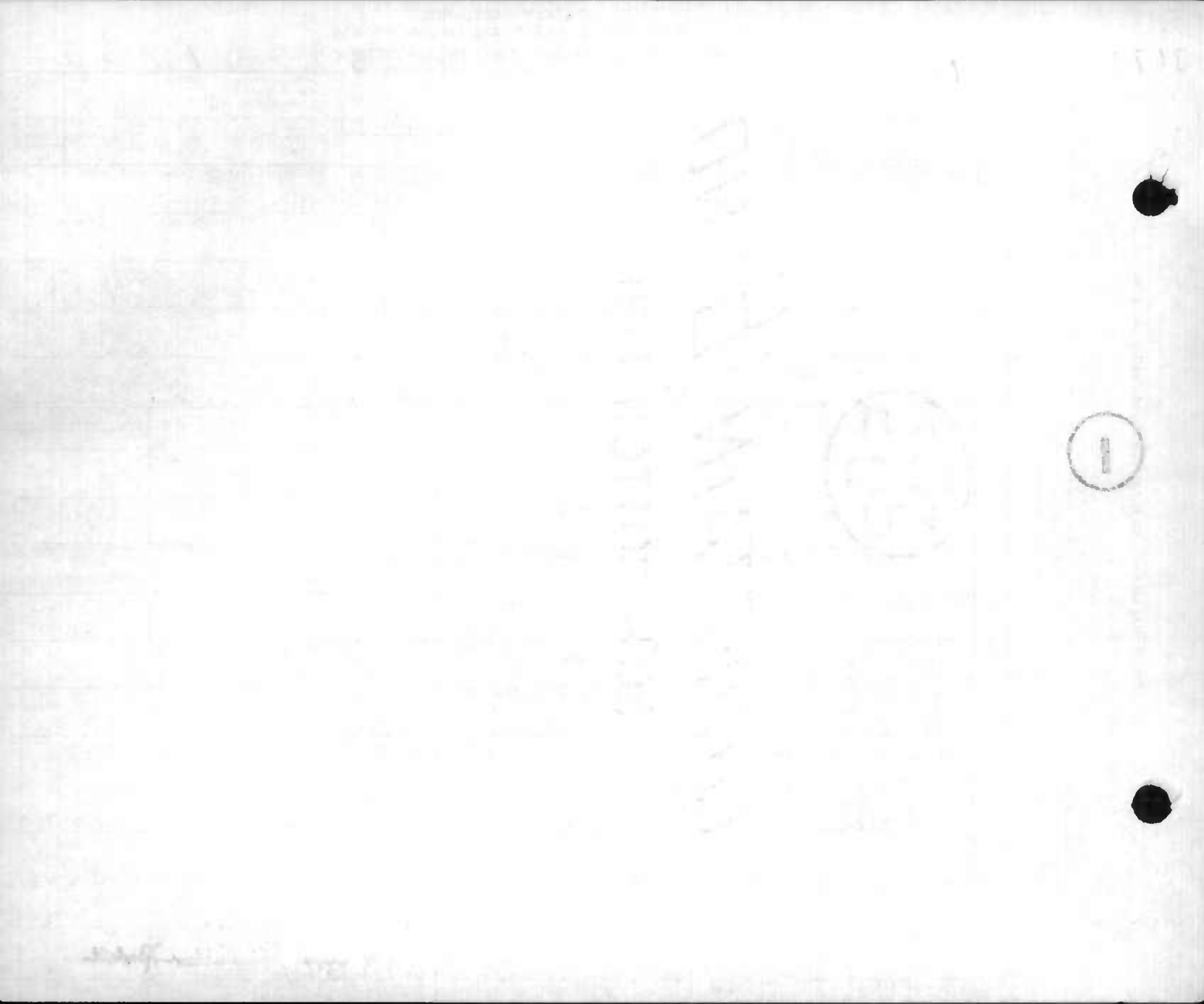
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC'D NO. 7 / 5 9

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|--|--|--------------------------------------|--|-------------------------------|--|--------------------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Clarence P. Robinson, Jr. | | | | | | | | XX | | 3-10 | | 1987 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| M | B | 7 6 58 | | 28 YRS. | | | | | | 3-10 | | 1987 | | | | 2:55 a. M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| MD | | USA | | | | Baltimore City, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | Mercy Hospital | | UNK | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 901 DRUID PARK LAKE DR. | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| CLARENCE P. ROBINSON, SR. | | JANNIE LYLES | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 215746750 | | CLARENCE P. ROBINSON, SR. | | 21239 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) <u>Ethanolism</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| death resulted from | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| <i>Dennis F. Smyth</i> | | Assistant | | 3-10-87 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Dennis F. Smyth, M.D. | | ADDRESS | | 111 Penn St., Balto., Md. | | 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| BURIAL | | 3/16/87 | | NEW CATHEDRAL CEM. | | BALTIMORE, MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | | | | | | MAR 13 1987 | | <i>Julia Davidson-Randall</i> | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGINS. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSMIT PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **07 / 60**

**1- FOR
STATE
REGISTRAR**

| | | | | | | | | | |
|---|----------------------------|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HILDA E. ROBINSON | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH 3 DAY 13 YEAR 1987 | | | | 2b. HOUR
M 11:20 P M | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH 5 DAY 3 YEAR 1904 | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 7c. DATE PRONOUNCED DEAD
MONTH 3 DAY 13 YEAR 1987 | | 7d. HOUR
M 11:20 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Accounting
21218 | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3809 S. Fenchurch Rd., | |
| 14. FATHER'S NAME
FIRST William MIDDLE Keefer LAST Keefer | | | | 15. MOTHER'S MAIDEN NAME
FIRST Saidee MIDDLE Davis LAST Davis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
212 01 5774 | | 17. INFORMANT
William N. Burgee, ADDRESS Same | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | |
| (b) | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |

| | | | | | |
|---|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | | | |
|---|--|--|--|--|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <u>William M. Zane</u> M.D. Assistant MEDICAL EXAMINER DATE SIGNED 3-15-87 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. ADDRESS 111 Penn St., Balto., MD 21201 | | | | | |

| | | | | | | | |
|--|--|------------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | 23d. LOCATION
CITY OR TOWN Balto. COUNTY County STATE MD | |
| 24. FUNERAL DIRECTOR NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Pindell</u> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201.

16-253

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approval or

French F. H. J.

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Items 18a thru 22a Film G627 5/27
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 REG. NO. 07761

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|---------------------------------|--|--|--|------------------|--|---|--|-------|--|----------------------------|--|------|--|----------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | HOUR | | | | | | | |
| Lakiesha | | | | | | Robinson | | 5 | | 3 | | 21 | | 1987 | | M | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | | |
| Female | | Black | | 11 18 1986 | | YRS. 4 | | MONTHS | | DAYS | | HOURS | | MIN. | | 3 | | 21 | | 1987 | | 2:31 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | | | St. Agnes Hospital | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | | | | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 1376 N. Calhoun St., 21217 | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Leroy | | | | Robinson, Jr. | | | | Lillian | | | | Higgins | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | | | | | |
| N/A | | | | | | | | Lillian Higgins | | | | 1376 N. Calhoun St., 21217 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Sodium Chloride intoxication/Hyponatremia | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | | | P.M. 3/2 1987 | | | | Subject apparently ingested sodium chloride | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | | | |
| | | | | Unknown | | | | Unknown | | | | | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | | | | | | | | | | | | | |
| M.D. Chief MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | | | | | |
| DATE SIGNED 3-22-87 | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. | | | | | | | | | | | | | | | | | | | | | | | |
| ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN | | | | COUNTY | | | | STATE | | | |
| Burial | | | | 3-26-87 | | | | Mount Zion Cemetery | | | | Baltimore | | | | Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | | | | | | | | | | | | | | |
| Bailey Funeral Home 1348 N. Calhoun St. 21217 | | | | | | | | | | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | | | | | | | | | | | | |
| APR - 2 1987 | | | | | | | | | | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN ITEM 18. RETAIN PAGE 3 TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP 533
 DHMH - 17
 (VR A15 ME (5))

12750 78

11/11/1978
20% COL. 11/11/78

3/8 11

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSFER PERMITS, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | |
|---|----------|--|---|
| #18a, -22a., -G-625, -bv | | STATE OF MARYLAND | |
| FOR Med. Ex., 3/6/87 | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | |
| REGISTRAR Gbj | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | REG. NO. 07762 | |
| Mark A. Robinson | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2/ 3/ 19 87 | |
| 3 SEX M | 4 RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 8 27 64 | 6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman | | 12b. KIND OF BUSINESS OR INDUSTRY Mfg. | |
| 13a. STATE Md. | | 13b. COUNTY | |
| 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 1117 Gilmore St. 21217 | | 14. FATHER'S NAME FIRST MIDDLE LAST Robert Hernandez | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joyce Robinson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Ms. Joyce Robinson 1117 N. Gilmore | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Craniocerebral Injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1 27 1987 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject struck on head | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 408 E. Federal St. Balto., City, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | ADDRESS 111 Penn St. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/7/87 | |
| 23c. NAME OF CEMETERY OR CREMATORY Eastview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons | | ADDRESS 1701 Laurens St. FEB 6 1987 | |
| 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |



048771 MAR 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07163

| | | | | | | |
|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARYLAND J. ROBINSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 26, 1987 | | 2b. HOUR A M
10:35 A | |
| 3. SEX
F | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
7-6-1938 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
BALTO | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
489-40-0617 | | 17. INFORMANT
ADDRESS
GLENN A. CHIARILLI, 700 S. LINWOOD AVE. 21224 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Sepsis / DIC
DUE TO, OR AS A CONSEQUENCE OF
(c) Deformed Bladder / Aspiration
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 1/2 hrs
336 days
31 days | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Severe Radiation Toxicity Resulting in Bleeding per Rectum / Bladder. | | | | | | |
| 19a. DATE OF OPERATION
3/6/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Hemorrhage | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February , 19 87 , to March 26 , 19 87 , that (I) (we) last saw the deceased alive on March 26 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
John R. Roberts MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-26-87 |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
CREMATION | | 23b. DATE
3-28-87 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW MEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO CO MD. |
| 24. FUNERAL DIRECTOR
NAME
THOMAS J. SKRADA | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall |

RELEASED AS NON-MED PER MR. HENRY & DR. KORELL. MEDICAL EXAMINER'S OFFICE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card-tags. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

E0295624

8 REG. NO. 07164

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Robert R Robinson, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 15 87 | | 2b. HOUR
MIN.
11:55 PM | | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 26 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
W.J. Dickey | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Ellicott City | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
732 Oella Ave. 21043 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alfred Robinson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Johannah Demonrel | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 217-18-6901 | | 17. INFORMANT
Patricia Vetter | | 21. ADDRESS
Freeway Landsdowne, MD 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Bladder Cancer | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Renal insufficiency | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-24-87 , 19____, to 3-15-87 , 19____, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 3-9-87 , 19____, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
W E Gormley | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul Gormley | | | 22e. ADDRESS
900 Catow Ave. Baltimore MD 21209 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
19 March 87 | | 23c. NAME OF CEMETERY OR CREMATORY
Good Shepherd Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ellicott City Howard MD | | | |
| 24. FUNERAL DIRECTOR
NAME
SIACK Funeral Home | | | CITY
Ellicott City MD | | ZIP
21043 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
1861 8 1 JAW | |

BP _____

2025000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07165 | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Mary J. Rockel | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-2-87 | | 2b. HOUR
3A |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
9-02-01 | | 6. AGE (IN YEARS) (AT BIRTHDAY)
85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)
FSK Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress - Clothing Mfg. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. | | 13b. COUNTY
--- | 13c. CITY OR TOWN
Baltimore | 13d. STREET ADDRESS / ZIP CODE
1 N. Decker Street- 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Francis J. Dvorak | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Barbara Anna Prowchowski | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-03-2156 | | 17. INFORMANT ADDRESS
Mrs. Marilyn E. Dikin-Daughter-21234 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF*
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) --- | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2/27/87 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27 19 87 , to 3/2 19 87 that (I) (we) lost saw the deceased alive on 3/2 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
E. Dubin | | DEGREE
M.D. | | 22c. DATE SIGNED
3/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ethan Dubin | | 22e. ADDRESS
FSK Hospital Easton Ave | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery; Baltimore, Md. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
John A. Moran, Inc. Funeral Home | | DATE REC'D. BY REGISTRAR
3000 E. Baltimore Street Baltimore, Md. 21224 | | | |
| 25. REGISTRAR'S SIGNATURE
--- | | 26. REGISTRAR'S SIGNATURE
--- | | | |

3-2-87 34

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10-00 P. 0-01

Time

Rocky

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U. S. A.

U. S. A.

Rocky

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W.

x

U. S. A.

U. S. A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene. Pages 1 and 2 should be filed with the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8207766 | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE WILBERT RODGERS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 3 87 | | 2b. HOUR
11:15 AM |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
10 10 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SELF EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY
RESTAURANT |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE RODGERS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
YESPER WILLIAMS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-01-5147 | | 17. INFORMANT MRS. ARLEAN BURTON
ADDRESS BALTIMORE, MD. 21207
4101 BARRINGTON ROAD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC PROSTATIC CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27 , 19 87 , to 3/3 , 19 87 , that (I) (we) lost
saw the deceased alive on 3/3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bryan K. Bartle MD | | DEGREE | | 22c. DATE SIGNED
3/3/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRYAN K. BARTLE | | 22e. ADDRESS
MERCY HOSPITAL 301 ST PAUL PLACE
BALT MD 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/7/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PARK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | 24. PREPARED BY
WINTER & SONS FUNERAL HOME, INC.
NAME ADDRESS
2501 GWYNNS FALLS PKWY, BALTO, MD, 21216 | | | |
| 25. PREPARED BY
MAR 04 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

20718

10-10-10

(A)

10-10-10

10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 REG NO 07767 | |
|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 / 23 / 87 11:10 AM | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES E. RODGERS | | | | 2b. DATE OF DEATH MONTH DAY YEAR 3 / 23 / 87 11:10 AM | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 3 16 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven V.A. Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator | | 12b. KIND OF BUSINESS OR INDUSTRY AMERICAN LOCKING CO. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. CITY, STATE, ZIP CODE MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES RODGERS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE UNKNOWN | | 16. STREET ADDRESS / ZIP CODE 1814 N. Smallwood ST. 21216 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WWII 216-12-1281 | | 17. INFORMANT BALTIMORE, MD. 21239 MAGALENE BROWN 1419 WINSTON AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Metastatic Adeno Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19 1987, to 3/23/ 1987, that (I) (we) lost saw the deceased alive on 3/23 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE B. Aristimundo MD | | DEGREE MD/32 | | 22c. DATE SIGNED 3/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARISTIMUNDO | | 22e. ADDRESS Loch Raven VA Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 3/28/1987 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VETERANS | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | 23e. DATE RECEIVED BY REGISTRAR 3/31/1987 | | | |
| 24. FUNERAL HOME NAME ADDRESS NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY, BALTO, MD, 21216 | | 25a. DATE RECEIVED BY REGISTRAR 3/31/1987 REGISTRAR'S SIGNATURE [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please submit this certificate to the Baltimore City Health Department, 201 W. Preston St., Baltimore, Maryland 21201. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARGARET ROETTGER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-15-87 | | | 2b. HOUR
8:30am | | |
| 3 SEX
Female | | 4. RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
6-23-1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 yrs. YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE
(COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kirkwood House 6401 Loch Raven Blvd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY
American Woolen Co. | | |
| 13a. STATE
Md. | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6401 Loch Raven Blvd 21239 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Anthony Lombardi | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Algive | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO.
216-07-6570 | | 17 INFORMANT ADDRESS
George Roettger 205 E. Joppa Road Unit 1903 21204 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure + cardiac standstill
DUE TO, OR AS A CONSEQUENCE OF
(b) chronic congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hours
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/7 , 19 73 , to 3/9 , 19 87 that (I) (we) last saw the deceased alive on 3/9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true, I did not view the body after death.) | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. Gresser</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Gresser | | | | | 22e. ADDRESS
6112 York Road | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPEECH)
Burial | | | 23b. DATE
3-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Schmidnek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Pedersen</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 87 REG. NO. 07769 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | | |
| WALTER William Rohde Sr. | | | | 3 7 87 | | 12 ³⁰ PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| MALE | | White | | 4 05 08 | | 78 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Balt. City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | MERCY HOSPITAL 301 St Paul Pl | | Merchandizing Supervisor G.&E. | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | | | Baltimore | | | | 4330 Shamrock Ave. 21206 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| George Rohde | | Nettie Gill | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| no | | 212-05-3156 | | Mrs. Hanna Rohde | | Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 3wks</u> | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure with hypercalcemia</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bladder Cancer</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> 19 <u>87</u> , to <u>3/7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Robert M. Antherelli, MD | | MD | | | | 3/7/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Robert M. Antherelli, MD | | 301 St Paul Pl. Balt MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | Mar. 11, 1987 | | Oak Lawn | | Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leonard J. Ruck Inc. Baltimore, Maryland | | | | MAR 10 1987 | | Julia L. Ruck | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove companion pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|--|
| Item # 1, Film G 625 3/20/87 CM
FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Edith Ethel M. Rollins | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 17 1987 | | | | | 11. HOUR
6:00A M. |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3-21-1920 | | 6. AGE IN YEARS LAST BIRTHDAY
66 YRS | | 7. UNDER 1 YEAR
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 8. UNDER 24 HRS
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3304 Kenyon Avenue | | | | 12a. USUAL OCCUPATION
(IF OF WORK OR MOST OF WORKING LIFE)
Ref. Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
A.S. Abell | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3304 Kenyon Ave. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert A. Smith | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gertrude Freeman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
239-30-4308 | | 17. INFORMANT
ADDRESS
Richard L. Neighoff, Same as 13e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
BILATERAL CEREBROVASCULAR Accidents - Vegetative state | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-25 1987, to 17 MARCH 1987, that (I) (we) lost saw the deceased alive on 17-2-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Francis A. Clark | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3-17-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Francis A. Clark, M.D. | | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3-20-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | 25a. DATE RECEIVED BY REGISTRAR
MAR 18 1987 REGISTRAR'S SIGNATURE
R. R. Rucker | | | | | |

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Insurance Co. of New York, Inc., 100 Broadway, N.Y.

Policy No. 100-1000000

Policy No. 100-1000000

100-1000000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Solomon Romano | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 6 87 | | | 2b. HOUR
1:32AM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 25, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
YUGOSLAVIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MERCHANT | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MARYLAND | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4123 BUENA VISTA AVE. #21211 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NISSIW ROMANO | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RENA UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-30-9524 | | 17. INFORMANT
MRS. VERONICA ROMANO
4123 BUENA VISTA AVE. BALTO., MD 21211 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RUPURED AAA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION
3/5/87 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute Abdomen | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/5 19 87 , to 3/6 19 87 , that (I) (we) lost saw the deceased alive on 3/6 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.) | | | | | | | | | | |
| 22b. SIGNATURE
Paul Cooper | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/6/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL COOPER | | | 22e. ADDRESS
201 E UNAV PKWY / BALTO / MD 21218 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
MAR. 8, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
CHEVRA AHAVAS CHESD | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RANDALLSTOWN BALTO. MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia S. ... | | |

MEDICAL CERTIFICATION

29

BP

7

049401 APR - 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07772
REG. NO.

FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Glenna G. Rose

2a. DATE OF DEATH
MONTH DAY YEAR
3 23 19 87

2b. HOUR
M
4:05 P.M.

3. SEX
Female

4. RACE
White

5. DATE OF BIRTH
MONTH DAY YEAR
Sept 26, 48

6. AGE (IN YEARS)
LAST BIRTHDAY
38 RS.

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD.

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY
home

13a. STATE
Maryland

13b. COUNTY
B

13c. CITY OR TOWN
Baltimore

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS
4401 Chalet Ct. 21206

14. FATHER'S NAME
FIRST MIDDLE LAST
Lee Ray Cary

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edna

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
578-64-5574

17. INFORMANT
5955
7509 Leona St
Forestville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

19. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?
YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
TITLE (SPECIFY)
D. Assistant MEDICAL EXAMINER
DATE SIGNED 3-24-87
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
30Mar1987

23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery

23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland PG Md

24. FUNERAL DIRECTOR
NAME ADDRESS
Robert E Wilhelm
Funeral Home Suitland, Md

25a. DATE REC'D. BY REGISTRAR
APR - 2 1987

25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3, AND PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

4/9

4

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

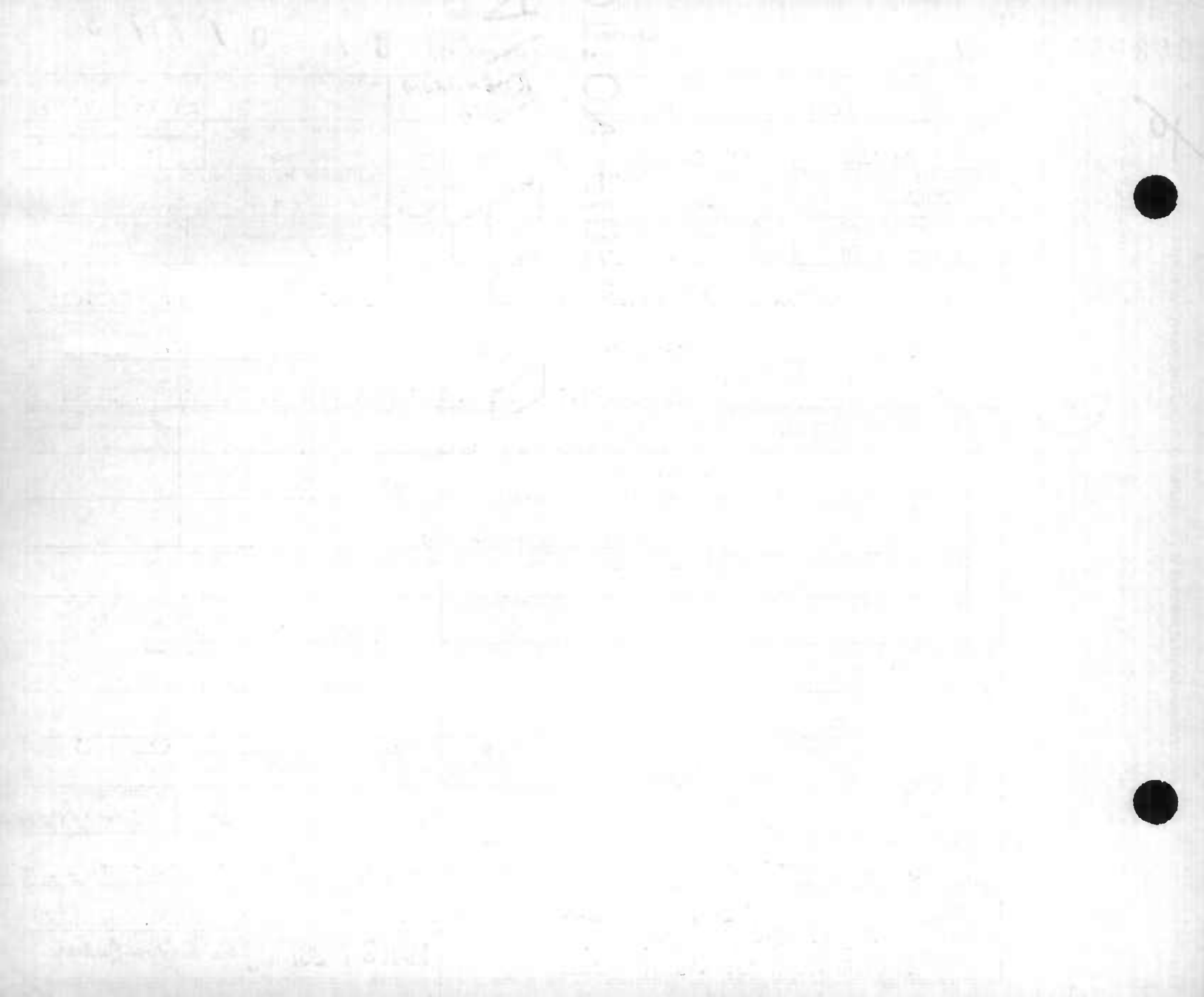
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07773 | | |
|--|--|--|---|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PAUL | | | FIRST MIDDLE
ROSENBAUM | | LAST
ROSENBAUM | | 7a. DATE OF DEATH
MONTH DAY YEAR
3 21 87 | | | 2b. HOUR
400 AM | | |
| 3 SEX
MALE | | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 07 07 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
POLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TAILOR | | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHES | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SHLOMO ROSENBAUM | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARTEL ZUCKER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-28-6248 | | | 17. INFORMANT
ADDRESS
RUTH ROSENBAUM 4241 LABYRINTH RD. 21215 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>basal ganglia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>bacterial pneumonia</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 19 <u>87</u> , to <u>3/21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Barry Wertheimer | | | | | | DEGREE
MD | | | 22c. DATE SIGNED
5/21/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Barry Wertheimer | | | | | | 22e. ADDRESS
5847 B Western Run Dr. BALTIMORE MD 21207 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(BY WHOM)
BURIAL | | | 23b. DATE
3/22/87 | | 23c. NAME OF CEMETERY OR CREMATORY
RUDOMER VEREIN CEMETERY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO. MARYLAND | | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | | | | 25. DATE REC'D BY REGISTRAR
MAR 27 1987 | | | | | |
| | | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | | | | |



046741 MAR 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Ruth | | MIDDLE
(nmi) | | LAST
(aka Coleman)
Rosenthal | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 18, 1936 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
50 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Pharmacy | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
-- -- -- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
615 S. Durham St. #21231 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Rosenthal | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl Marshall | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No -- -- -- | | 16b. SOCIAL SECURITY NO.
219-32-2978 | | 17. INFORMANT
ADDRESS
Marlin Coleman- 615 S. Durham St. #21231 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma Esophagus.</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION
7/21/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma Esophagus | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>June</u> 19 <u>86</u> to <u>Feb.</u> 19 <u>87</u> , that (I) first Host saw the deceased alive on <u>2/13</u> 19 <u>87</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) personally did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Ashwin Mehta M.D.</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/9/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ashwin Mehta M.D. | | | | 22e. ADDRESS
1050 Old North Pt. Rd. Balto., Md. 21224 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill Memorial Gar.-Baltimore County, Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME
George A. Weber & Sons Inc.-705 S. Ann St. | | | | 25a. NAME OF HOSPITAL OR OTHER INSTITUTION
MAR 09 1987 | | 25b. NAME OF HOSPITAL OR OTHER INSTITUTION
MAR 09 1987 | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return all pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other fatal event, the medical examiner must be notified.

BP _____

DHMH-16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Void Death Certificate

#87-07775

048248 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

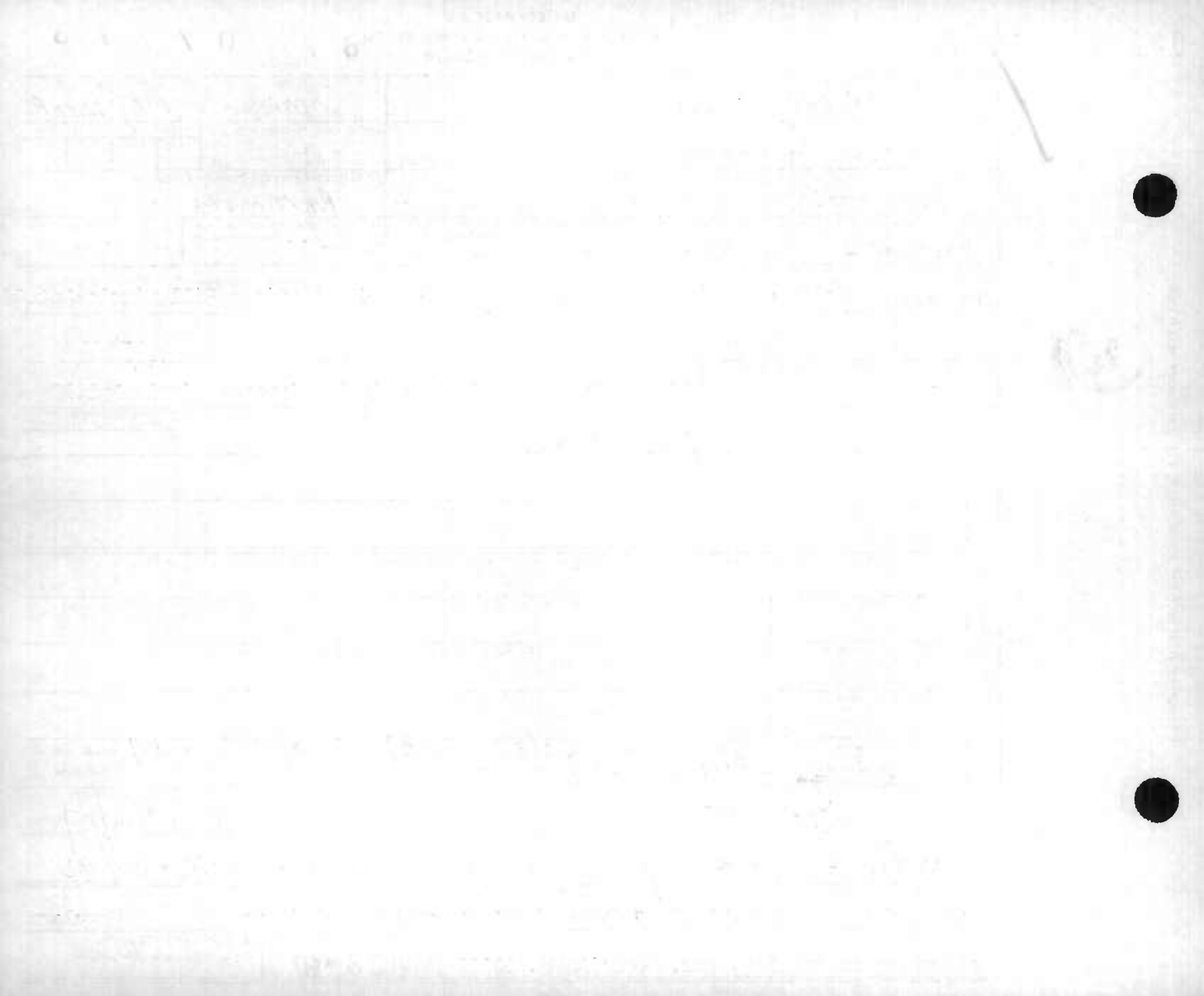
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07775

REG. NO.

| | | | | | |
|--|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FRIEDA (nmi) RUBIN | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 19, 1987 | | 2b. HOUR
12:50 P.M. |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 31 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BARTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BARTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Levin Ave Hebrew Geriatric Center + Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Homemaker | |
| 13a. STATE
MARYLAND | | 13b. CITY OR TOWN
Baltimore | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
3424 Carriage Hill Circle Apt. 24 21133 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nartow | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-56-7675 | | 17. INFORMANT ADDRESS
Samuel M. Rubin 15 Cinnamon Circle Apt. 1D 21133 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 3/19 19 87 , to 3/19 19 87 , that (we) lost
saw the deceased alive on 3/19 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (we) (did) view the body after death. | | | | | |
| 22b. SIGNATURE
Estelita O. Kim, M.D. | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/19/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ESTELITA O. KIM, M.D. | | 22e. ADDRESS
Levin Ave Hebrew Geriatric Center + Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
March 20, 1987 | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley, Inc. Dundalk, Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
He Davidson-Randall | |

BP



048489 MAR 10 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07777

FOR
STATE
REGISTRAR

REG. NO.

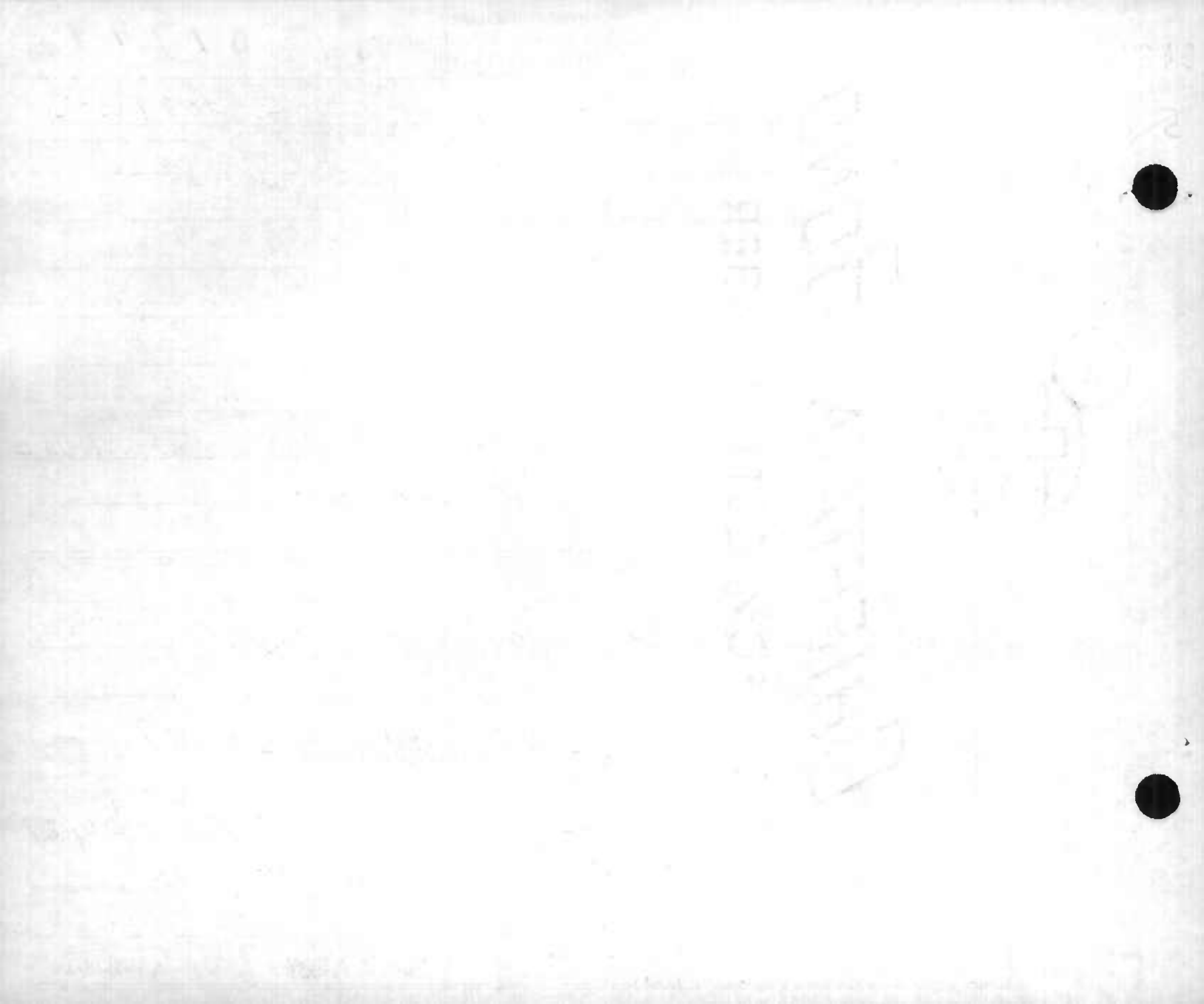
| | | | | | | | | | | | |
|--|--|--|--|--|------------------------------------|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Silvia J Rubin</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 20 87</i> | | 2b. HOUR
<i>2:25 AM</i> | | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>WHITE</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>JAN. 13, 1912</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>75</i> | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>NEW YORK</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE CITY</i> MD | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SINAI HOSPITAL</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>AT HOME</i> | | | |
| 13a. STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>BALTO.</i> | | 13c. CITY OR TOWN
<i>BALTO.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>3615 FORDS LA., APT. 711 #21215</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>SAMUEL LEDER</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>ANNA UNKNOWN</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>068-22-9197</i> | | 17. INFORMANT
<i>MR. WILLIAM RUBIN</i> | | 17a. ADDRESS
<i>901 DROPLEAF CT. BALTO., MD</i> | | 21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>several days</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>3/10/87</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Perforated duodenal ulcer</i> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>3:00 19 87</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>Sinai Hospital</i> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/20 19 87</i> to <i>3/20 19 87</i> , that (I) (we) lost saw the deceased <i>3:00</i> above, (I) (we) (and) (and) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Petersen</i> | | DEGREE
<i>Petersen</i> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>3/20/87</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Petersen</i> | | 22e. ADDRESS
<i>Sinai Hospital</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>MAR. 22, 1987</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>BALTIMORE HEBREW</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>REISTERSTOWN BALTO. MD</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>SOL LEVINSON & BROS. INC.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 27 1987</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rudolph</i> | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be reviewed at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain portions of this certificate and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 87 07178
REG. NO. | |
|---|--|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CLORA RUFFIN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
03 28 87 | | | 2b. HOUR
9.08 A.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
Col | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct 5, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Raymaker | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Addie Best | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
220244700 | | 17. INFORMANT
ADDRESS
Mrs. Nora Johnson 1114 McKean Ave 21217 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>CEREBRAL VASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SENILE DEMENTIA</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 31 19 82, to 03/28 19 87, that (I) (we) last saw the deceased alive on 03/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Kuang-yen Huang M.D. | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
3/28 87 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KUAN G - YEN HU ANG M.D. | | | | | 22e. ADDRESS
Bon Secours Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cryot | | | 23b. DATE
4-1-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mam Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO Co Mo | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ 2222 W. NORTH AVE | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Jordan-Ladner | | | | |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---|--|---|---|--|--|----------|--------|
| 1- STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 3- 28- 87 | | | 5:30AM |
| Charles | | W. | Ruhmann | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | | |
| Male | White | MONTH DAY YEAR
1- 29- 18 | | 69 | | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Md. | U.S.A. | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | 637 N. Robinson St. 21205 | | | Foreman-Mach. | | Amer./Smelt. | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | |
| Md. | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 637 N. Robinson St. 21205 | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | |
| William | | Audrey | | Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17 INFORMANT ADDRESS | | | | | |
| yes | | W.W.11 | 219-01-3470 Gwendolyn Ruhmann - same as above | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Progressive Metastatic Malignant Melanoma</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>10</u> <u>1988</u> to <u>3</u> <u>1988</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>3/18</u> <u>1988</u> , and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death <u>Part by report from funeral home. Cause unknown</u> | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | |
| <u>[Signature]</u> | | | | 3/28/87 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | |
| <u>Kovitz</u> | | <u>University of Maryland Hospital</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | 3-30-87 | Meadowridge Cem. | | Balto. Md. | | | |
| 24 FUNERAL DIRECTOR
NAME | | 3331 Brehms Lane 21213
ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Schimunek Funeral Home, Inc. | | | | MAR 31 1987 | | <u>[Signature]</u> | | |



2019 10/10/2019

2019 10/10/2019

2019 10/10/2019

048643 MAR 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 877780 | |
|--|----------------------|---|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT R. RUSH | | | | | | | | 2a. DATE KNOWN OF DEATH 3-25-87 | | 2b. HOUR 6:01 P | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH 5 12 57 | 6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 3-25-87 | | 7d. HOUR 6:01 P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1804 N. Calvert Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2205 Elsinore Ave. 21215 | | | |
| 14. FATHER'S NAME FIRST Unkn MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Evelyn MIDDLE LAST Rush | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | (IF YES, GIVE WAR OR DATES) - | | 16b. SOCIAL SECURITY NO. Unkn | | 17. INFORMANT Iola Hedgepeth ADDRESS 2205 Elsinore Ave. 21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia and fatty liver
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) chronic alcoholism
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 3-26-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/31/87 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March ADDRESS F/H West 4300 Wabash Ave. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 30 1987 25b. REGISTRAR'S SIGNATURE | | | | | | | |

08775



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a possible homicide.

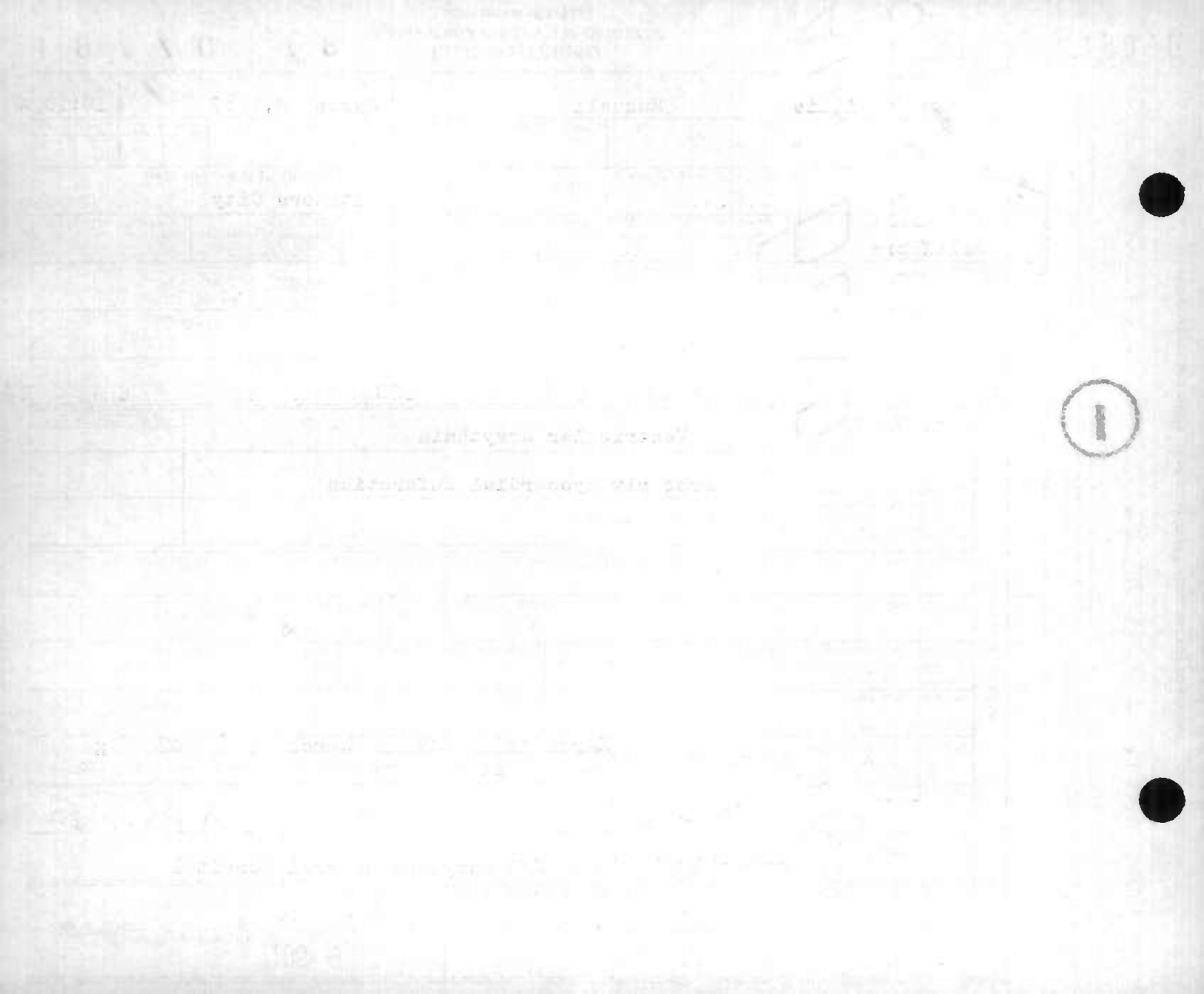
048542 MAR 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07781
REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Willie Russell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 22, 1987 | | | 2b. HOUR
10:10^{AM} | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 3 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MD. GENERAL HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISAB. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE, | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1604 VINCENT CT. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JIMMIE WILSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARIAH SPANN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
248325078 | | 17. INFORMANT ADDRESS
JIMMIE WILSON, JR. 4624 REISTERTOWN RD 21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(b) Probably Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from March 22, 1987 to March 22, 1987 , that XX (we) last saw the deceased alive on March 22, 1987 , and that in XX (our) opinion death occurred on the date and hour and from the cause stated above. (1) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Tsong Huang | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/22/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Tsong Huang M.D. | | 22e. ADDRESS
C/O Maryland General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN | | 23d. LOCATION
CITY OR TOWN
BALTO. COUNTY STATE
MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

046176 MAR-15

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07782

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|-------------------|------------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST
<i>Ethel</i> | MIDDLE
<i>T.</i> | LAST
<i>Ryan</i> | 2a. DATE OF DEATH | | MONTH
<i>3</i> | DAY
<i>3</i> | YEAR
<i>87</i> | 2b. HOUR
<i>5:00 P.M.</i> | |
| 3. SEX
<i>F</i> | 4. RACE
<i>Caucasian</i> | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| | | MONTH
<i>7</i> DAY
<i>22</i> YEAR
<i>1929</i> | | | <i>87</i> YRS | | MONTHS
<i>8</i> DAYS
<i>12</i> HOURS
<i>12</i> MIN. | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Md.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>FSK Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>home</i> | | | | |
| 13a. STATE
<i>Md.</i> | 13b. COUNTY
<i>Balto.</i> | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<i>317 S. Ellwood Ave. 21224</i> | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST
<i>Henry</i> | | MIDDLE
<i>Myers</i> | | LAST
<i>Carrie</i> | | FIRST
<i>Carrie</i> | | MIDDLE
<i>Stuffel</i> | | LAST
<i>Stuffel</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>215-40-0115</i> | | 17. INFORMANT <i>Albert Schuler</i>
<i>Charles Thomas-317 S. Ellwood 21224</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>3/3</i> P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>2/17/87</i> 19 <i>87</i> , to <i>3/3</i> 19 <i>87</i> , that (1) (we) lost saw the deceased alive on <i>3/3</i> 19 <i>87</i> , and that in my (a) opinion death occurred on the date and hour and from the causes stated above (If (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>E. Dubin</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>3/3/87</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Ethan Dubin</i> | | 22e. ADDRESS
<i>FSK Hospital - Eastern Ave</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>3/5/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Security Process</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Joseph N. Zannino</i> | | | | ADDRESS
<i>263 S. Conkling St.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 05 1987</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

BP _____

10-0-017 Charles Robert-317 A. Elwood 2122

(Faint, illegible text)

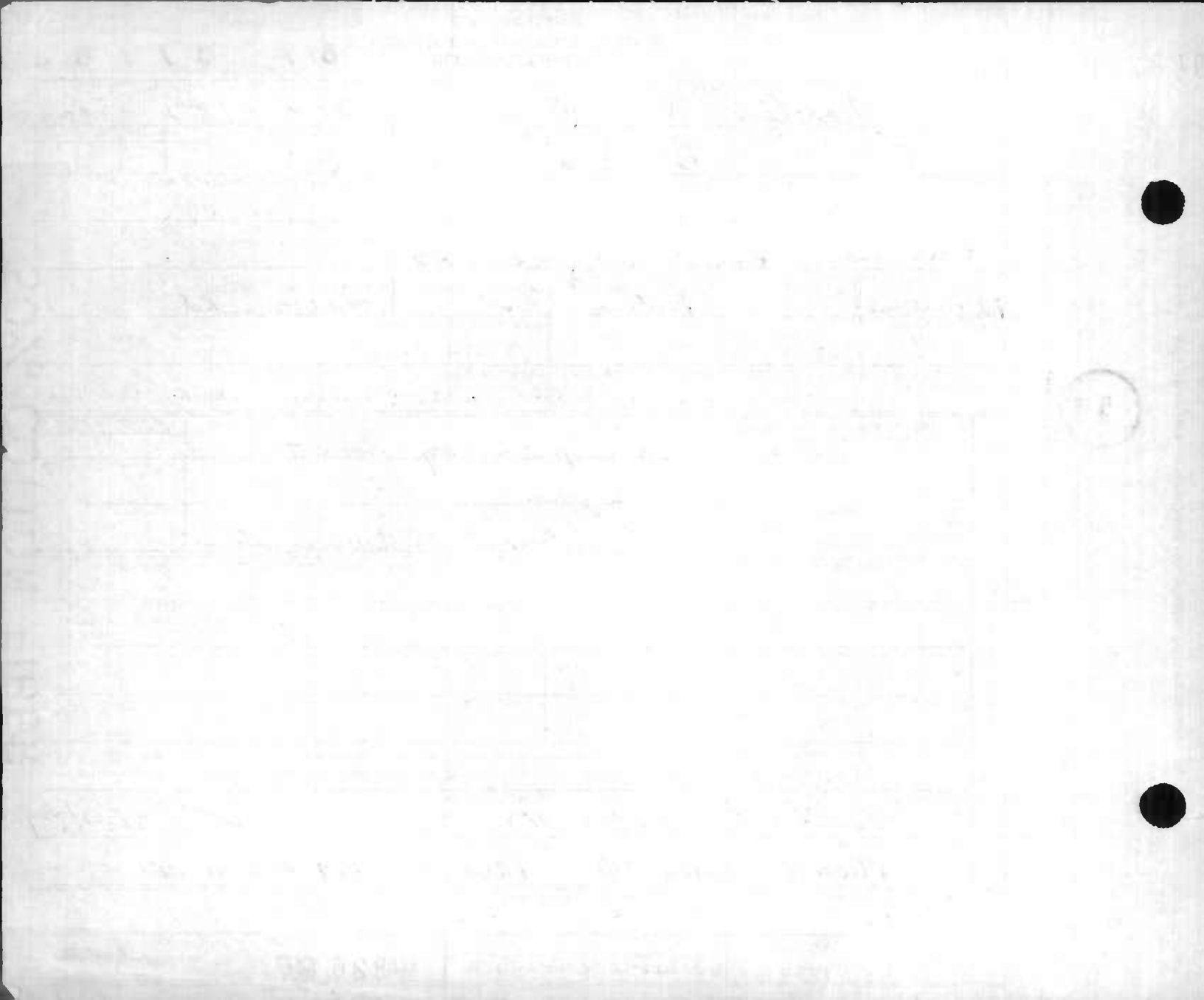
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1 and #2 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified of a case.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 87 07183
REG. NO. | |
|--|--|--|--|---|--|--|--|---|-------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Madeline ✓ Ryan</i> | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3/29/87</i> | | | 2b. HOUR
<i>5 AM</i> | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 9 18</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>69</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Phoenix, Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Balto. City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Medical Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<i>Md (Baltimore)</i> | | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>5411 Lothian Rd 21212</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>John B. Ryan Sr.</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Velma A. Ryan</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>n/a</i> | | 17. INFORMANT
ADDRESS
<i>Shirley Butler 5411 Lothian Rd.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>peritoneal instrumentation</i> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Michael Brave MD</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>3/29/87</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MICHAEL BRAVE MD</i> | | | | 22e. ADDRESS
<i>FRANCIS SCOTT KEY MEDICAL CENTER</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>3/28/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Stevenson Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Monkton, Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Leroy O. Dyett</i> | | | | | | 24b. ADDRESS
<i>4600 Liberty Heights</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 26 1987</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please review closely pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

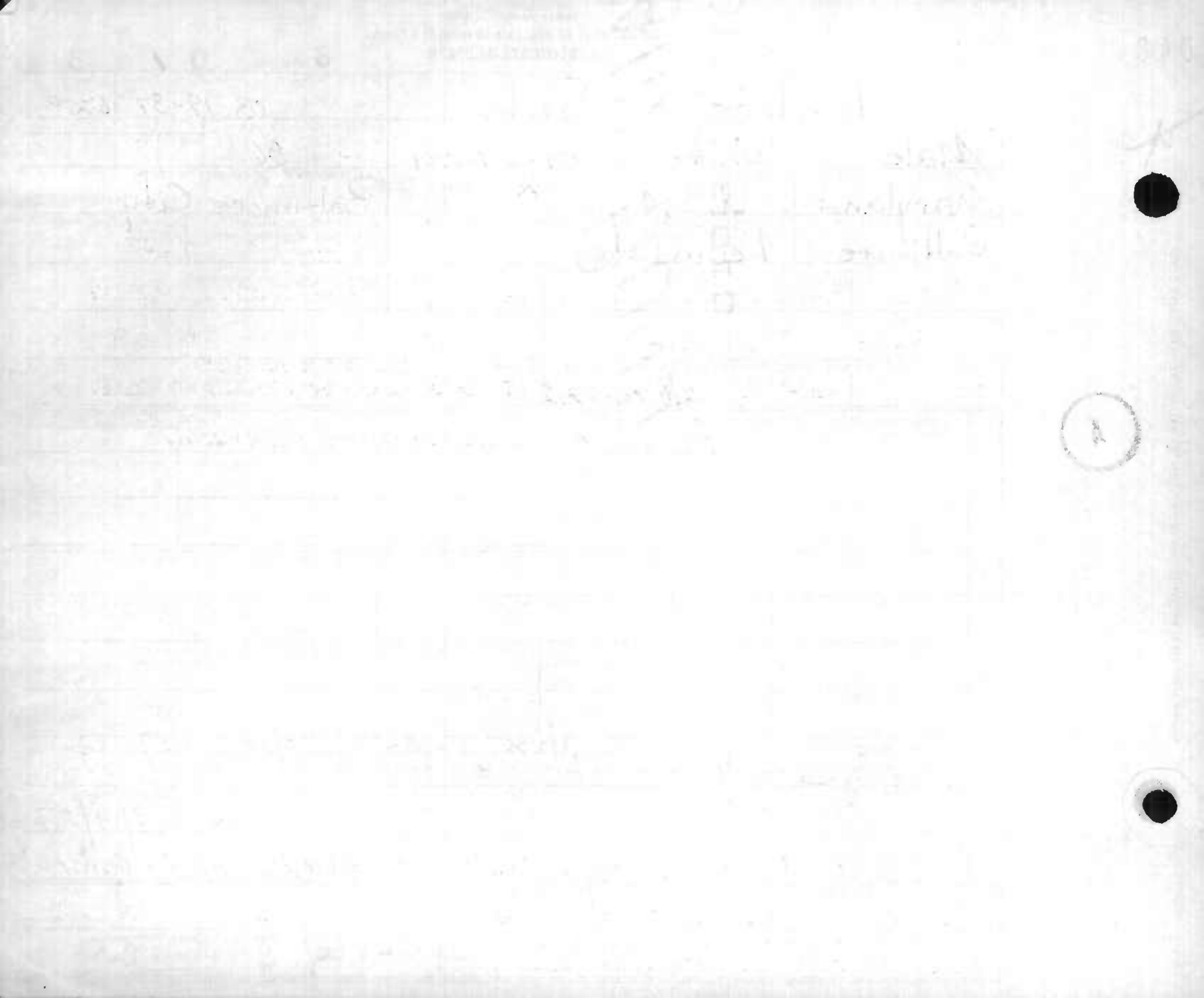
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07184

| | | | | | | | | |
|--|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Isadore R. Sachs | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03-19-87 | | 2b. HOUR
6:25P.M. | | | |
| 1. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
09-04-1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | |
| 7b. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Levindale | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY
TAXI | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
OWINGS MILLS | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HERMAN SACHS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ADA UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWI-NAVY 218-03-5712 | | 17. INFORMANT
MRS. EDITH A. SACHS
37F TAHOE CIR, OWINGS MILLS, MD 21117 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POSSIBLE ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from 3/19 , 19 83 , to 3/19 , 19 87 , that (we) last saw the deceased alive on 3/19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.) | | | | | | | | |
| 22b. SIGNATURE
Estrelita O. Kn | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/19/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ESTRELITA O. Kn | | | | 22e. ADDRESS
LEVINDALE HEBRON GERIATRIC CENTER + HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAR. 22, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
ANSHE EMUNAH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE RECD. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Henderson-Randall | | |

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

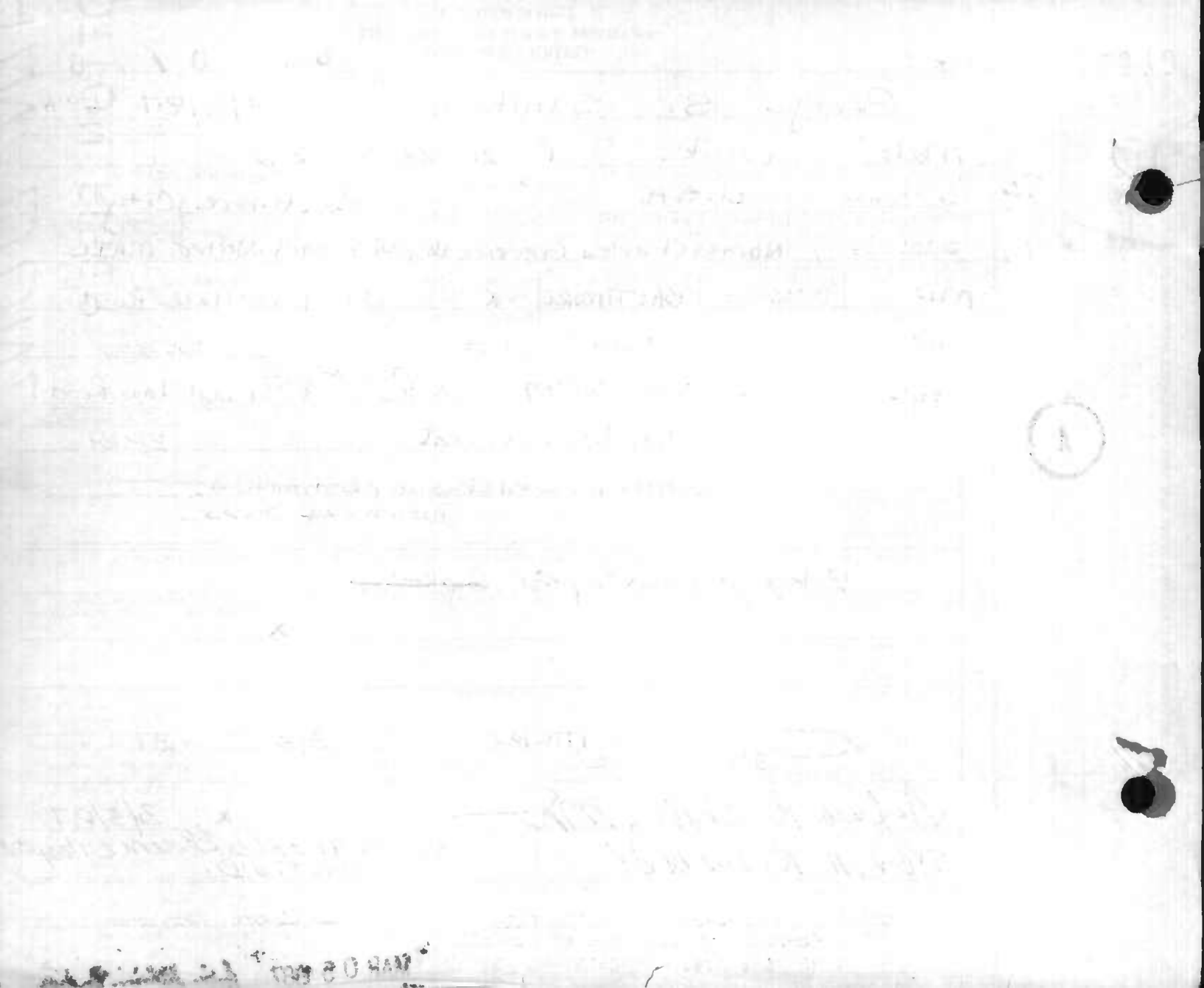
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the first seven pages. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic cause, the examiner must be notified immediately.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|------------------------------------|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) George S. Sahlbom | | | | | 2a. DATE OF DEATH MONTH 3 DAY 3 YEAR 1987 | | 2b. HOUR 5⁰⁰ A M | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH 1 DAY 20 YEAR 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Worker | | 12b. KIND OF BUSINESS OR INDUSTRY MAIL | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 8031 Wallace Road 21222 | | | |
| 14. FATHER'S NAME FIRST Olaf MIDDLE LAST Sahlbom | | | | 15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE LAST Not Known | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. WW II 535-38-387 | | 17. INFORMANT Dorothy Sahlbom ADDRESS Wife 8031 Wallace Road. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Decompensated Chronic Obstructive Pulmonary Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/3/87 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Staphylococcal Sepsis, Systemic II | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 11/15/87 , 19 87 , to 3/3 , 19 87 , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Sylvia R. Medley MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 3/3/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SYLVIA R. MEDLEY | | | | | | 22e. ADDRESS North Charles General Hospital BALT, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-6-87 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk ADDRESS 7922 Wise Ave. Dundalk, MD 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 05 1987 25b. REGISTRAR'S SIGNATURE A. R. Medley | | | |

BP



049082 APR 15

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07186

| | | | | | | | | | | | | | |
|---|---------|--|--|---|--|--|--|---|--|--------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE KNOWN
OF DEATH | | ESTIMATED
MONTH DAY YEAR | | 26. HOUR | |
| Robert | | E. | | Sanderlin | | | | 3/ 26/19 | | 87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 7c. DATE
PRONOUNCED
DEAD | | 24. HOUR | |
| MALE | Black | 12 27 38 | | 48 YRS. | | | | | | 3/ 26/19 | | 87 P M | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | | | | | Baltimore City, | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | |
| Baltimore | | 5105 Litchfield Ave. | | Construction | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| MD | | | | Balto. | | | | 4967 Edgemere | | | | 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | |
| James | | Sanderlin | | Elizabeth | | Cherry | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| NO | | 216-34-2302 | | Eleanor Richardson | | 2773 Alameda | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Mallory-Weiss Syndrome, ruptured (gastroesophageal) with</u>
<u>Mediastinitis</u>
(b) <u>Alcoholism</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Alcoholism</u> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE <u>William M. Zane</u> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE
SIGNED 3/27/87 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| William M. Zane, M.D. | | | | 111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | | | 3/30/87 | | | | Balto. Cem. | | | | Balto. MD | |
| 24. FUNERAL DIRECTOR
NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | |
| Jeff Miller Funeral Services | | | | 4611 Park Heights Ave. 21215 | | | | APR 1 1987 | | | | Julia Sanderlin-Ridgely | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT RECORD. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. TO DIVISION OF VITAL RECORDS: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

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DHMH - 17
(VR A15 ME (5))

NOTED FOR

W. H. H. H.



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **07187**

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---------------------------|--|--------------------------|--|--------------------------------------|--|-----|--|------|--|----------|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTI- MATED | | MONTH | | DAY | | YEAR | | 7b. HOUR | | | | | |
| MURIEL | | L. | | SANDERS | | | | 3-12-87 | | 9 | | | | | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 7d. HOUR | | | | | |
| Female | Black | Feb. 16, 1961 | | 26 YRS. | | | | | | 3-12-87 | | | | | | | | 5:30 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Md. | | U.S.A. | | | | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| Baltimore | | 2007 Ellsworth Avenue | | None | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | |
| Md | | City | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2007 Ellsworth Ave. 21213 | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | | | | | | | | | | | |
| HARRY | | SANDERS | | | | NAOMI | | NORRIS | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | | | |
| (YES, NO, OR UNKNOWN) | | (YES, GIVE WAR OR DATES) | | No | | 21213 | | Naomi Sanders | | Balto. Md. 21213 | | | | | | | | | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>Strangulation</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | |
| (b) _____ | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) _____ | | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

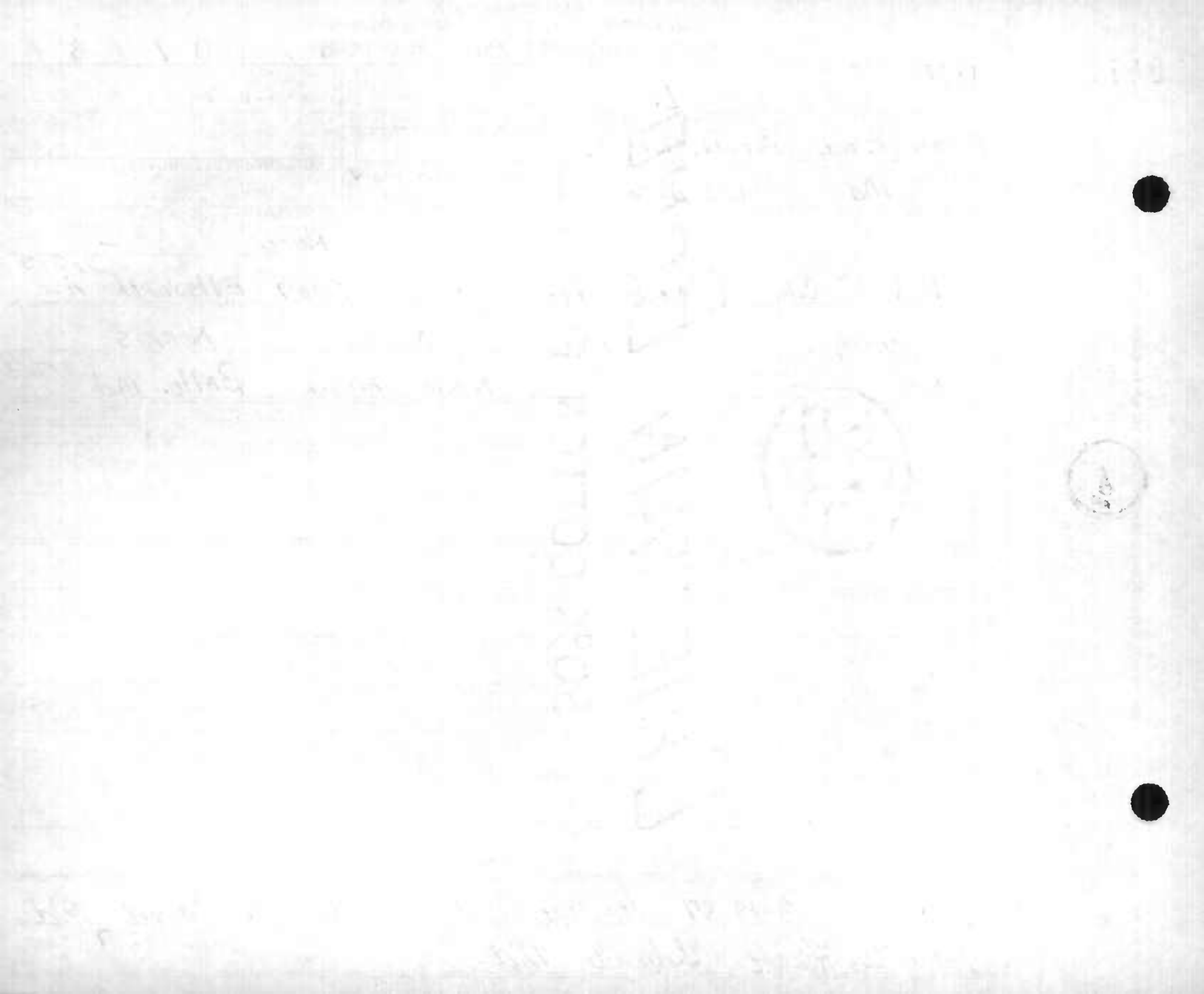
| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR
? 3-12-87 19 | | subject found strangled | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | 2nd fl. bathrm. | | 2007 Ellsworth Avenue Baltimore, Maryland | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Margarita A. Korell, M.D. | | M.D. Assistant | | 3-13-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| | | 111 Penn Street | | | |

| | | | | | | | |
|---------------------------------|--|-----------|--|------------------------------------|--|--------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 3-18-87 | | St. Luke Cemetery | | Lykerville Carroll Md. | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | DATE REC'D. BY REGISTRAR | |
| Harry W. Haight | | | | Lykerville, Md. | | MAR 16 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

4
047321

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ATTACH WITH FORM 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



047292 MAR 17

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07 / 88
REG. NO.

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| BRUCE STEVENS SANDS | | | MARCH 12, 1987 | | | 4:03 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Male | White | OCT. 27, 1944 | 42 | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | USA | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | Union Memorial Hospital | | Inspector | | | Construction | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| Maryland | | | | | | Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| Harvey Andrew Sands | | | Helen Cox | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| No | | | | | | 1715 White Oak Ave.
Scott Sands Balto., Md. 21234 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Shock 2° to Gastro Intestinal bleed.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe ETOH overuse</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Advanced liver disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> 19 <u>81</u> , to <u>3/12</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Stephen Laiken</u> | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>3/13/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen Laiken, M.D. | | | 22e. ADDRESS
6805 York Rd. Baltimore, Md. 21212 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Cremation | | | 3/14/87 | | Greenmount | | Baltimore City, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | 25. REG'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | MAR 16 1987 | | | <u>J. H. Davidson-Randall</u> | | |

MEDICAL CERTIFICATION

9
9
1

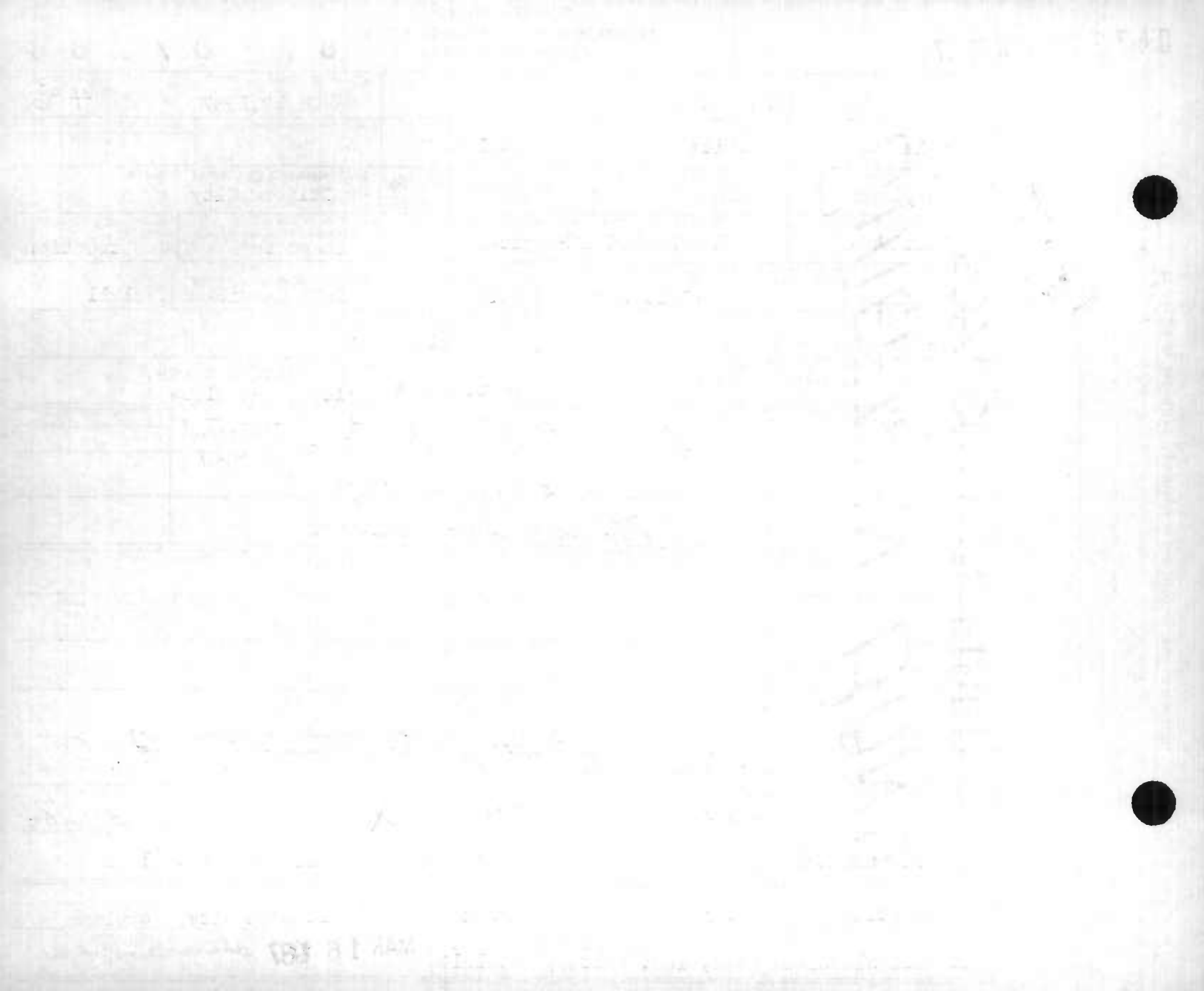
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed fully in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR | | 87 | | 87 | | 07789 | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| MARGARET M. SANDS | | | | | | | | 3 23 87 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| FEMALE | | WHITE | | 6 3 27 | | 59 YRS. | | 7 20 A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Deaton Hospital + Medical Center | | | | Mail Clerk | | Advertising | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Baltimore | | Lansdowne | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 433 Bigley Avenue 21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Ward | | | | Wiley | | | | Thelma | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 217-20-8586 | | Richard W. Sands 439 Bigley Ave. 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widely metastatic cervical carcinoma.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 27</u> 19 <u>87</u> , to <u>March 23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 22</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>George Taker M.D.</u> | | | | | | | | 3/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| George Taker, M.D. | | | | 600 Light H. Bldg. Md. 21230. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 3/26/87 | | Meadowridge Mem. Pk. | | Elkridge Howard Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 21229 | | MAR 26 1987 | | | |

100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8707790

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
ELMER COVELL SAUERHOFF | | | 2a DATE OF DEATH
MONTH DAY YEAR
MARCH 29, 1987 | | | 2b HOUR
12 38 pm | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 22 00 | | 6 AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
VA MEDICAL CENTER BALTIMORE | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b KIND OF BUSINESS OR INDUSTRY
Civil Service | | |
| 13a STATE
Maryland | | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Lansdowne | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
327 Second Avenue, 21227 | |
| 14a FATHER'S NAME
FIRST MIDDLE LAST
Robert Sauerhoff | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Covell | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II & Korea 213-03-4230 | | 17 INFORMANT ADDRESS
Elmer B. Sauerhoff, 327 Second Avenue | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
B. Kristmundur MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
3/29/87 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
KRISTMUNDUR | | | 22e ADDRESS
3900 Loch Raven Blvd. Baltimore MD | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b DATE
4/2/87 | | 23c NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24 FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | 25a DATE OF RECORD BY REGISTRAR
APR - 2 1987 | | 25b REGISTRAR'S SIGNATURE
[Signature] | | | | | |

BP

048772 MAR 31 1987

FOR STATE REGISTRAR 3/31/87 DAD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07191 REG. NO.

| | | | | | | | |
|--|--|--|--|---|---------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Marie E. Sauter</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3/27 3 27 87</i> | | 7b. HOUR
<i>10³⁰ PM</i> | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>3 29 03</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>83</i> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore city</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Med Center</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>RETIRED</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>BALTO</i> | | 13c. CITY OR TOWN
<i>BALTO</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP
<i>1 Canton Blvd 21224</i> | | 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>CHRISTOPHER C. KEYS</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>MARY UNKNOWN</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | |
| 16b. SOCIAL SECURITY NO.
<i>217-16 8089</i> | | 17. INFORMANT
ADDRESS
<i>JEAN LACHER 412 S. TAYLOR AVE. 21221</i> | | 17. INFORMANT
ADDRESS
<i>ESSEX MD.</i> | | 17. INFORMANT
ADDRESS
<i>ESSEX MD.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| (b) <i>pneumonia</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Michael J. Bravos MD</i> | | | | 22c. DATE SIGNED
<i>3-27-87</i> | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MICHAEL BRAVOS MD</i> | | | | 22c. ADDRESS
<i>4740 Eastern Ave, Balto Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BORIAL</i> | | 23b. DATE
<i>3-30-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>DAKLAWN CEM.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTO MD</i> | |
| 24. FUNERAL DIRECTOR
<i>HOFFMANN-SKARDA 3218 HUDSON ST.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 30 1987</i> | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]



048182 MAR 23

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF THE WORD "DECEASED". GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM 18. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
JSMDHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07792
REG. NO.FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|---------|---|--------|---|--|---|---|---|--------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| Claude C. Savage | | | | | ESTIMATED | | <input type="checkbox"/> | 3-20 | 1987 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | 7d. HOUR |
| Male | Black | MONTH | DAY | YEAR | LAST BIRTHDAY | MONTHS | DAYS | HOURS | MIN. | 7:17 P M |
| | | 11 | 2 | 59 | 27 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Baltimore | | USA | | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | 4505 Wakefield Ave. | | | | - | | - | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Maryland | | - | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21216 4505 Wakefield Ave Apt. B | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| Spencer | | Juila | | - | | Juila M. Lawson | | Lawson | | |
| 16a. WAS DECEASED EVER (YES, NO, OR UNKNOWN) | | 16b. IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | 16c. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| No | | - | | - | | Juila M. Lawson | | 4407 Belvieu Ave. 21216 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Narcotic intoxication</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | |
| (b) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | Subject used Drugs | | | | | | |
| | | ? P.M. 3-20-87 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | |
| AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | home | | 4505 Wakefield Ave., Balto., City | | MD | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | |
| <i>John E. Smialek</i> | | M.D. Chief | | MEDICAL EXAMINER | | 3-21-87 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn St., Balto., MD | | 21201 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | 3/25/87 | | King Park | | Randallstown, Md. | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| William C. March | | F/H 4300 Wabash Ave. | | | | MAR 23 1987 | | <i>Richard R. Rader</i> | | |



3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|---|
| <div style="text-align: right;"> REG. NO. 07193
 87 </div> | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
L. Genevieve Savage | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 5 87 | | 2b. HOUR
3:00A M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 24 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY?
NA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wesley Home, Inc. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lab. Technician | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2211 W Rogers Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry R. Savage | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy O. Chancey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-30-8627 | | 17. INFORMANT ADDRESS
Wesley Home Inc, 2211 W. Rogers Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Dysrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 86 , to 3/5 , 19 87 , that (I) (we) last saw the deceased alive on 3/5/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert J. Henss, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3-5-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-7-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Olivet Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR
NAME
BURGE-HENSS FUNERAL HOME | | | | ADDRESS
3631 FALLS RD 21211 | | DATE RECD. BY REGISTRAR
MAR 9 1987 | | REGISTRAR'S SIGNATURE
Frederick B. Henss | |

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48785

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified. **SAXON, JOSEPH**
OP/10/03STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|---|---|--------|--|-------------------|---|------|---|----------|------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | MIN. |
| JOSEPH | | | | SAXON | MARCH | 25 | 1987 | | 5:21 | A |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| MALE | WHITE | SEPT. 18, 1903 | | 83 | | MONTHS | | DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| BALTIMORE | JOHNS HOPKINS HOSPITAL | | | OWNER | | SHOE STORE | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| MARYLAND | | | | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| HARRY | | | | SOPHIA | | MIERSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| NO | | | | 577-01-6791 | | MRS. ADA SAXON APT. 406
6711 PARK HTS. AVE. BALTO., MD 21215 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypoxemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pulmonary edema</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 hrs
10 hrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute cholecystitis; inferior subendocardial myocardial infarct</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 20</u> , 19 <u>87</u> , to <u>March 25</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>March 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Hallie DeChant</u> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
3/25/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Hallie DeChant</u> | | | | 22e. ADDRESS
<u>Johns Hopkins Hospital</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | 23e. STATE | | |
| BURIAL | | MAR. 26, 1987 | | CHIZUK AMINO | | BALTIMORE | | MD | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 31 1987 | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

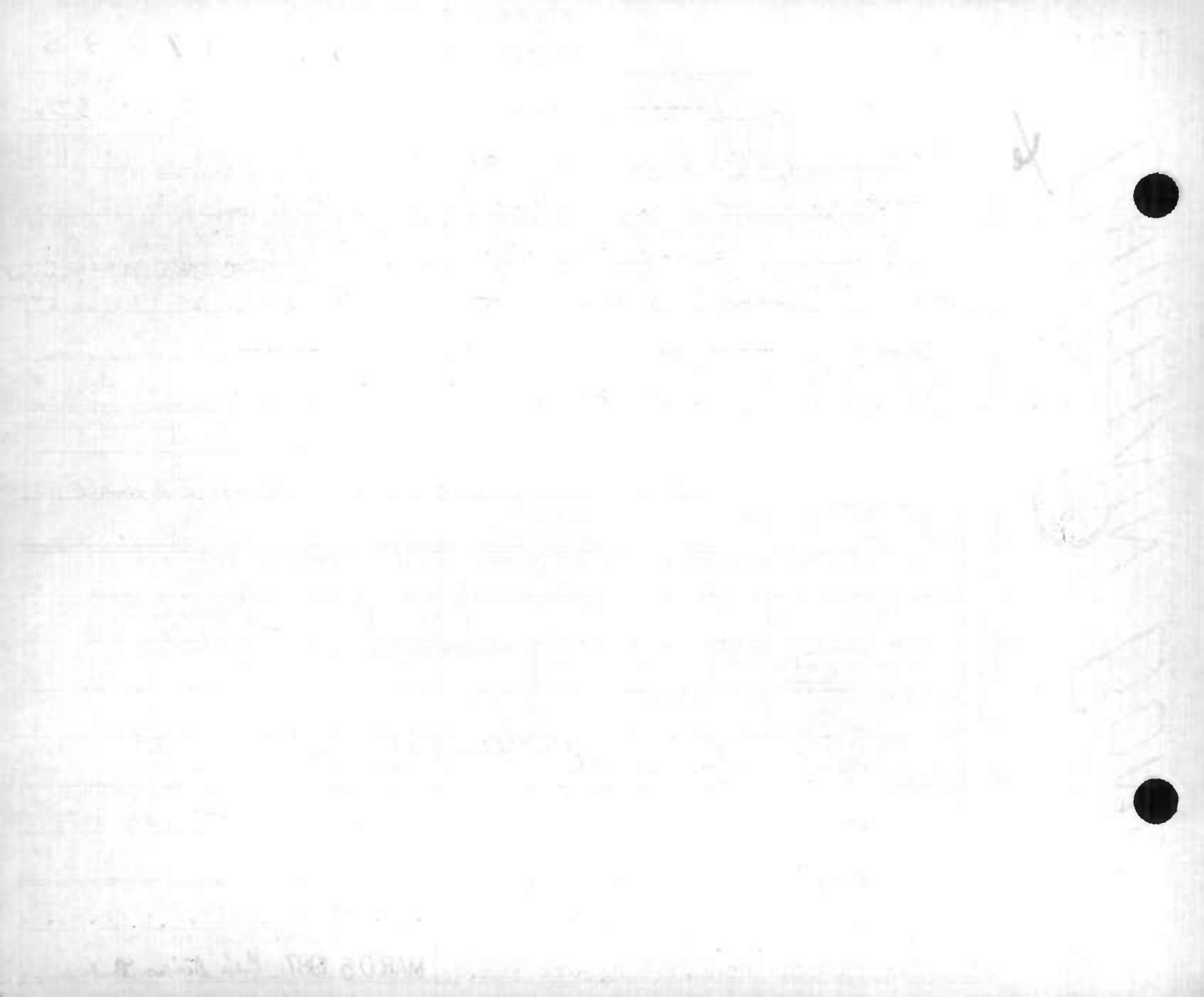
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be attached to the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07795 | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Kathleen ----- School</u> | | | | 2a. DATE OF DEATH MONTH <u>3</u> DAY <u>2</u> YEAR <u>87</u> | | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>6</u> DAY <u>01</u> YEAR <u>09</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VA.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore city</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>S.B.G.H. Balto. Md.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13e. STREET ADDRESS / ZIP CODE <u>1605 Schaefer St Baltimore</u>
<u>St. Villa St. Michael</u> 21230 | |
| 14. FATHER'S NAME FIRST <u>Ernest</u> MIDDLE ----- LAST <u>Thompson</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Frances</u> MIDDLE ----- LAST <u>Edwards</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>212349273</u> | | 17. INFORMANT ADDRESS <u>Charlotte shewbridge, same as above</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Resp. Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable metastatic lung disease & pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/27/87</u> , 19 <u>87</u> , to <u>3/2</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE | | | | 22c. DATE SIGNED <u>3/2/87</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>OH</u> | | | | 22e. ADDRESS <u>S.B.G.H.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>3/6/1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>glen Haven Mem.pk.</u> | | 23d. LOCATION CITY OR TOWN <u>glen Burnie</u> COUNTY <u>A.A.</u> STATE <u>CO. MD.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>balto. md. 21230</u> ADDRESS <u>McGully funeral home, 130 E. Port ave.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAR 05 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u> | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07796

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Marie Cunigunda Schaefer

2a DATE OF DEATH MONTH DAY YEAR
March 9, 1987

2b HOUR A. M.
8:30

3 SEX
Female

4 RACE
White

5 DATE OF BIRTH MONTH DAY YEAR
6 6 99

6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
87

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b CITIZEN OF WHAT COUNTRY?
U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD.

10 CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
711 South Baylis Street

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired

12b KIND OF BUSINESS OR INDUSTRY
Housework

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN
Md. Baltimore

13b INSIDE CITY LIMITS? YES ☒ NO ☐

13c STREET ADDRESS / ZIP CODE
711 S. Baylis Street 21224

14 FATHER'S NAME FIRST MIDDLE LAST
Peter W. Dotterweich

15. MOTHER'S MAIDEN NAME MIDDLE
Mary Fiedler

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) (IF YES, GIVE WAR OR DATES)
No

16b SOCIAL SECURITY NO.
213-10-1360

17 INFORMANT ADDRESS
Josephine M. Wurga 6709 Railway Ave. 21222

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Metastatic Carcinoma Pectus*
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____

CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
Severe Anemia

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE
Gracito V. P. Tricio M.D.P.A.

22c. DATE SIGNED
3/10/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS
703 S. Clinton St., Baltimore, Md. 21224

23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
3-12-87

23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus

23d. LOCATION CITY OR TOWN COUNTY STATE
Dundalk, Balto. Co., Md.

24 FUNERAL DIRECTOR NAME ADDRESS
Charles S. Zeiler & Son Inc. 901 S. Conkling St.

25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE
MAR 11 1987 Julia Davidson-Randall

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES A. SCHAMBURG, SR. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/29/87 | | | 2b. HOUR
1200 M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
3/16/30 DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SAINT KENEX AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Rep. | | 12b. KIND OF BUSINESS OR INDUSTRY
Computer Circuitry MEGR | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY BALTIMORE 13c. CITY OR TOWN Woodlawn | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1503 CLAIRIDGE ROAD 21207 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Frederick Schamburg | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Marie Ball | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
Korea 212-26-8062 | | 17. INFORMANT
ADDRESS
Marlene L. Schamburg 1503 Clairidge Rd. 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Fibrillation</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Anterior Myocardial Infarction</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hours
4 hours
4 hours | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Severe Coronary Artery Disease</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Coronary Artery Bypass Graft Surgery | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> to <u>March 29, 1982</u> , that (I) (we) last saw the deceased alive on <u>March 29, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jeffrey F. Cole, M.D.</u> | | | | 22c. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22d. DATE SIGNED
3/29/87 | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey F. Cole M.D. | | | | 22f. ADDRESS
3455 Wilkens Ave 21229 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/1/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>William A. Harrison</u> | | | | |

BP

78516

Age and sex of subject
Date of birth

78516

Age and sex of subject

Date of birth

78516

78516

Age and sex of subject

Date of birth

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Age and sex of subject

Date of birth

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Age and sex of subject

Date of birth

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Age and sex of subject

Date of birth

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the accompanying pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1 - FOR
STATE
REGISTRAR | | 87 07798
REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) JACOB SCHEIN | | | | | 2a. DATE OF DEATH
MONTH 3 DAY 1 YEAR 87 HOUR 345 P.M. | | | | |
| 3. SEX
987 M ALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 8 DAY 18 YEAR 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI Hospital | | | | 12. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
OWNER | | 12b. KIND OF BUSINESS OR INDUSTRY
SCRAP METAL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE MARYLAND 13c. COUNTY BALTIMORE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS / ZIP CODE
6013 WESTERN RUN DR. #21209 | | | | |
| 14. FATHER'S NAME
FIRST MOSES MIDDLE SCHEIN LAST SCHEIN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST JENNIE MIDDLE HORWITZ LAST HORWITZ | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) 219-05-7289 | | 17. INFORMANT MARVIN SCHEIN
6214 IVYMOUNT RD. BALTO., MD 21209 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1 , 19 87 , to 3/1 , 19 87 , that (I) (we) lost
saw the deceased alive on N/A , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Galaraga | | | | | 22c. DATE SIGNED
3/1/87 | | | 22d. ADDRESS
SINAI Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
MAR. 3, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | | 23d. LOCATION
CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25a. DATE RECD. BY REGISTRAR MAR 05 1987
25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their pleas remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Margaret V. SCHELLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03-25-87 | | | 2b. HOUR
540 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
01-21-1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Saint Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
1207 Circle Drive, 21227 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Prior | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edna Cowan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
J. Fred Scheller, 1207 Circle Drive 21227 | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute MI, s/p reux
DUE TO, OR AS A CONSEQUENCE OF
(b) anoxic encephalopathy
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-16-87 to 3-25-87, that (I) (we) last saw the deceased alive on 3-24-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Katherine Traczuk MD | | | DEGREE
Resident
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3-25-87 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KATHERINE TRACZUK | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc., | | | ADDRESS
21229 4107 Wilkens Ave. | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |



046690 MAR 17

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07800

| | | | | | | | | | |
|--|------------------|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Raymond Schilling | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
3/ 7/ 19 87 | | | | 2b. HOUR
10:24 AM | |
| 3. SEX
MALE | 4. RACE
CAUC. | 5. DATE OF BIRTH
MONTH DAY YEAR
7 4 17 | 6. AGE (IN YEARS)
LAST BIRTHDAY
69 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
3/ 7/ 19 87 | | 7d. HOUR
AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
724 S. Lakewood Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
724 S. LAKEWOOD AVE 21224 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MARTIN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE KAMIMIECKI | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-03-7556 | | 17. INFORMANT
ADDRESS
MRS STELLA CEGIELSKI 6225 PENN RD 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cachexia | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Charles P. Kokes | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
3/8/87 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | ADDRESS
111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE Co. MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Kaczorowski Funeral Home | | | | ADDRESS
2525 Fleet St. | | 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Dindon-Randall | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE SECURED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transmission form. This must be done within 72 hours after death. The funeral director must file this form with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows an injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07801 | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>LOUIS R. SCHISLER</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>3/6/87</i> | | 2b. HOUR
<i>6 am</i> |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH MONTH DAY YEAR
<i>10/31/01</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>85</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>BALTIMORE</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>US</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE CITY</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>FSK HOSP.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Laborer</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Retired</i> | |
| 13a. STATE
<i>M.D.</i> | | | 13b. COUNTY
<i>BALTIMORE</i> | 13c. CITY OR TOWN
<i>BALTIMORE</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>John Schisler</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Elizabeth Nottenberger</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>218-10-1155</i> | 17. INFORMANT ADDRESS
<i>Robert P. Schisler, 5631 Frankford Ave. 21206</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>respiratory arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>pulmonary edema</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>cardiac ischemia</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/5/87</i> 19____ to <i>3/6/87</i> 19____, that (I) (we) last saw the deceased alive on <i>3/6/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>ella Janczew</i> | | DEGREE
<i>M.D.</i> | | 22c. DATE SIGNED
<i>3/6/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ELLA JANCZEK</i> | | 22e. ADDRESS
<i>FSK HOSPITAL</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | 23b. DATE
<i>3-9-87</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Meadowridge</i> | 23d. LOCATION CITY OR TOWN
<i>Balto.</i> | 23e. COUNTY STATE
<i>Balto., MD</i> | |
| 24. FUNERAL DIRECTOR
<i>John C. Miller, Inc., 6415 Belair Rd., 21206</i> | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 10 1987</i> | 25b. REGISTRAR'S SIGNATURE
<i>John C. Miller</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the papers. Pages 7 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07802 | |
|--|--|--|--|---|--|--|--|--|--------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Linda M Schleicher</u> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>Mar. 3, 1987</u> | | | 2b. HOUR
<u>7:02</u> ^A | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>April 7, 1955</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>31</u> YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Ma.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>City</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Good Samaritan Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<u>Ma.</u> | | 13b. COUNTY | | 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>4606 Parkside Drive 21206</u> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<u>Donald C. Glaser</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>E. Patricia Heilman</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>no</u> | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>David P. Schleicher Same</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic Obstructive Pulmonary Disease</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> , 19 <u>87</u> , to <u>3/3</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Kevin Horgan</u> | | | | DEGREE
<u>MD</u> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3/3/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>KEVIN HORGAN</u> | | | | 22e. ADDRESS
<u>96 The Johns Hopkins Hospital</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Cremation</u> | | | | 23b. DATE
<u>Mar. 5, 1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Westview Memorial</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<u>Baltimore Balto. Md.</u> | | | |
| 24. FUNERAL DIRECTOR NAME
<u>Leonard J. Ruck Inc. Baltimore, Maryland</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 04 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

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24

DIVISION OF VITAL RECORDS, 301 PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07803

| | | | | | | | | | | | | |
|---|--------------|--|---|---|-------------|--|-------------------------------------|---|--|---|-----------------------|---------------|
| FOR
- STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Frank | MIDDLE
L | LAST
Schmitt | 2a. DATE KNOWN
OF ESTI-
MATED | | <input type="checkbox"/> MONTH
<input type="checkbox"/> 3 | DAY
23 | YEAR
19 87 | 2b. HOUR
M |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
1 19 19 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH DAY YEAR
3 23 19 87 | 2d. HOUR
1:29 P.M. | |
| 10. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Key Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
supervisor | | 12b. KIND OF BUSINESS
OR INDUSTRY
Londontown | | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3500 Elliott Street 21224 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Schmitt | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Gets | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
212 10 5136 | | 17. INFORMANT
ADDRESS
Mildred Schmitt 3500 Elliott Street 24 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Ident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE
SIGNED 3-24-87 | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
3/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Md | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Dabrowski | | | | ADDRESS
1005 Dundalk Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07804
REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Minnie Schneider | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03-25-87 | | 2b. HOUR
6:25 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
03-08-1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Levindale | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY
EDUCATION |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HYMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LIBBY UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
213-34-4012 | | 17. INFORMANT
MR. MISCHA SCHNIDER APT. 1302
111 HAMLET HILL RD. BALTO., MD 21210 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: SACRAL DECUBITUS, PERIPHERAL VASCULAR DISEASE W/ GANGRENOUS RT. TOES | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4/1/83 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 4/1/83 , 19 86 , to 3/25 , 19 87 , that (a) (we) last saw the deceased alive on 3/25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Estrelita O. Klu | | DEGREE
MD | | 22c. DATE SIGNED
3/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ESTRELITA O. KLU, MD | | 22e. ADDRESS
LEVINJANE HEBERON GERIATRIC CENTER + HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAR. 27, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH EL MEM. PARK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
RANDALLSTOWN BALTO. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | |
| 25b. REGISTRAR'S SIGNATURE
J. H. Davidson | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

SCHNIDER, MINNIE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completed and in the presence of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 1 and 2 to the State Dept. of Health and Mental Hygiene prior to the funeral. (Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the funeral. (Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the funeral. (Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the funeral. (Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the funeral.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, only a physician or a physician's assistant may sign this certificate.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place it in the container with the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2:34 P.M.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Rae B. Schoenfeld. | | | 2a. DATE OF DEATH MONTH DAY YEAR
3/8/87. | | | 2b. HOUR
14:34 hrs. M. | | | |
| 3. SEX
FEMALE | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
12 10 04. | | 6. AGE (IN YEARS LAST BIRTHDAY)
83. 82 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY, BALTO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital of Baltimore | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GUSTAV BRAUNSTEIN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leah Barad UNKNOWN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
578-50-7490 | | | 17. INFORMANT
MR. STEPHEN SCHOENFELD | | | 17a. ADDRESS
12705 NORTH POINT LA. LAUREL, MD 20708 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Chronic obstructive Airways D.
DUE TO, OR AS A CONSEQUENCE OF
(c) Ischaemic heart disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/8/87, 19____, to 3/8/87, 19____, that (I) (we) last saw the deceased alive on 3/8/87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Kim, Youngmee | | | DEGREE
9123 | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kim, Youngmee | | | 22e. ADDRESS
c/o Sinai Hospital of Baltimore | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
MAR. 10, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
KING DAVID MEM. GARDENS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FALLS CHURCH VIRGINIA | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD | | | 24b. ADDRESS
21215 | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07806
REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Stanley W Schroeder | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 3 18/87 | | | 2b. HOUR
10:50A | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
07 24 32 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY
Law | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
9305 Chanute Dr 20814 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard Peter Schroeder | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gertrude Soltwedel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1954-1956 | | 17. INFORMANT
ADDRESS
Irmgard A. Schroeder, same as #13 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Acute Non Lymphocytic leukemia

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12/87, 19 87, to 3/18, 19 87, that (I) (we) lost
saw the deceased alive on 3/18, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Neil Padgett MD MPH | | | | DEGREE | | 22c. DATE SIGNED
Mar. 18, 1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Neil Padgett | | | | 22e. ADDRESS
225 Greene St Balto 21211 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
March 21, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey Funeral Home
Bethesda-Chevy Chase, Inc.
7557 Wisconsin Ave. Bethesda, MD 20814 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the certificate from the permit, and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

048875 APR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07807

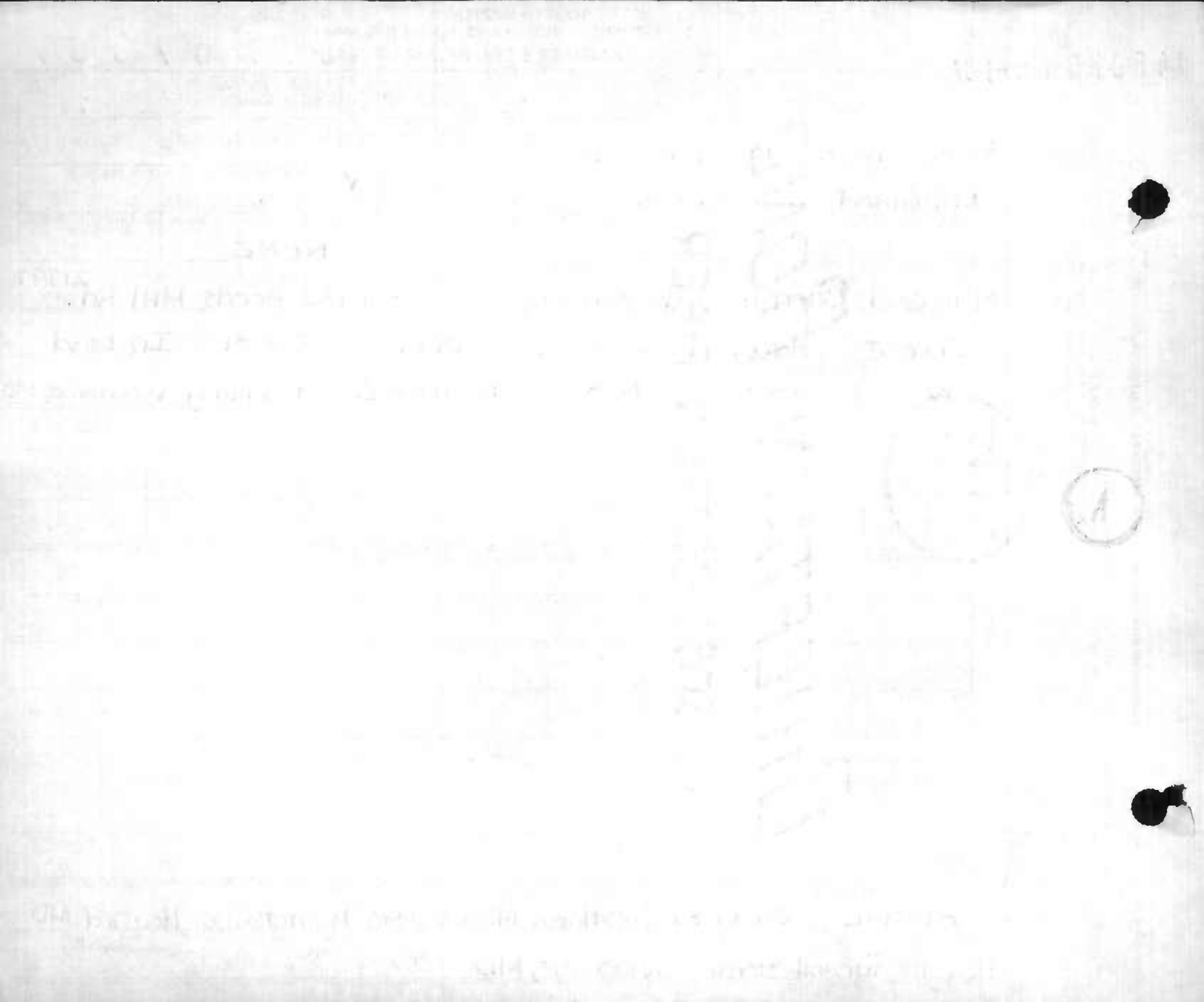
1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|------------------|---|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Christopher J. Schuhly | | | 2a. DATE KNOWN OF DEATH
XX MONTH DAY YEAR
3-29 1987 | | | 2b. HOUR
11:15 a. m. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
10-09-68 | 6. AGE (IN YEARS)
LAST BIRTHDAY
18 YRS. | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
3-29 1987 | | 2d. HOUR
11:15 a. m. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital - STU | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Woodbine | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest Harry Schuhly, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Doris Carol Ireland | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO --- N/A | | | | |
| 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Mr. & Mrs. Ernest Schuhly Woodbine, MD | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Blunt Head Injuries
DUE TO, OR AS A CONSEQUENCE OF
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
8160
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES XX NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR XX MONTH DAY YEAR
7:44 P.M. 3-28 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver of auto lost control and ran off road | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Woodbine & John Pickett Rds., Woodbine, Carroll Co., Maryland | | | | |
| 22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input type="checkbox"/> Accident XX Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED
3-30-87 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
04-01-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn Mem. Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mammothville Howard MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Haight Funeral Home Sykesville, MD | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

DIVISION OF VITAL RECORDS, 200 WEST PLESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 200 WEST PLESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07808
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HILMA VIRGINIA SCHWARTZ | | | 2a. DATE OF DEATH
MONTH 3 DAY 17 YEAR 87 | | | 2b. HOUR
3:00 P | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH 3 DAY 6 YEAR 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3000 Hollins Ferry Road 2B | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST JAMES MIDDLE L. LAST SHELDON | | 15. MOTHER'S MAIDEN NAME
FIRST ELIZABETH MIDDLE L. LAST LINHERT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212 05 2522 | |
| 17. INFORMANT
Ferndale, Maryland | | 18. ADDRESS
21061 Geraldine Albright #2 Second Avenue S | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIORESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF


(b) **CORONARY INSUFFICIENCY**


DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**MINUTES****YEARS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/85 19 to 3/19/87 19, that (I) (we) lost
saw the deceased alive on 3/19/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
 | | | | DEGREE | | 22c. DATE SIGNED
3/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID ROSE M.D. | | | | 22e. ADDRESS
200 Hospital Drive Glen Burnie, Md. | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
CREMATION | | 23b. DATE
3/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonville Balto. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Raymond C. Fink Glen Burnie, Md. 21061 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate remains the property of the State of Maryland. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

U.S. AIR FORCE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20330
MEMORANDUM FOR THE SECRETARY
SUBJECT: [Illegible]
[Illegible text follows]



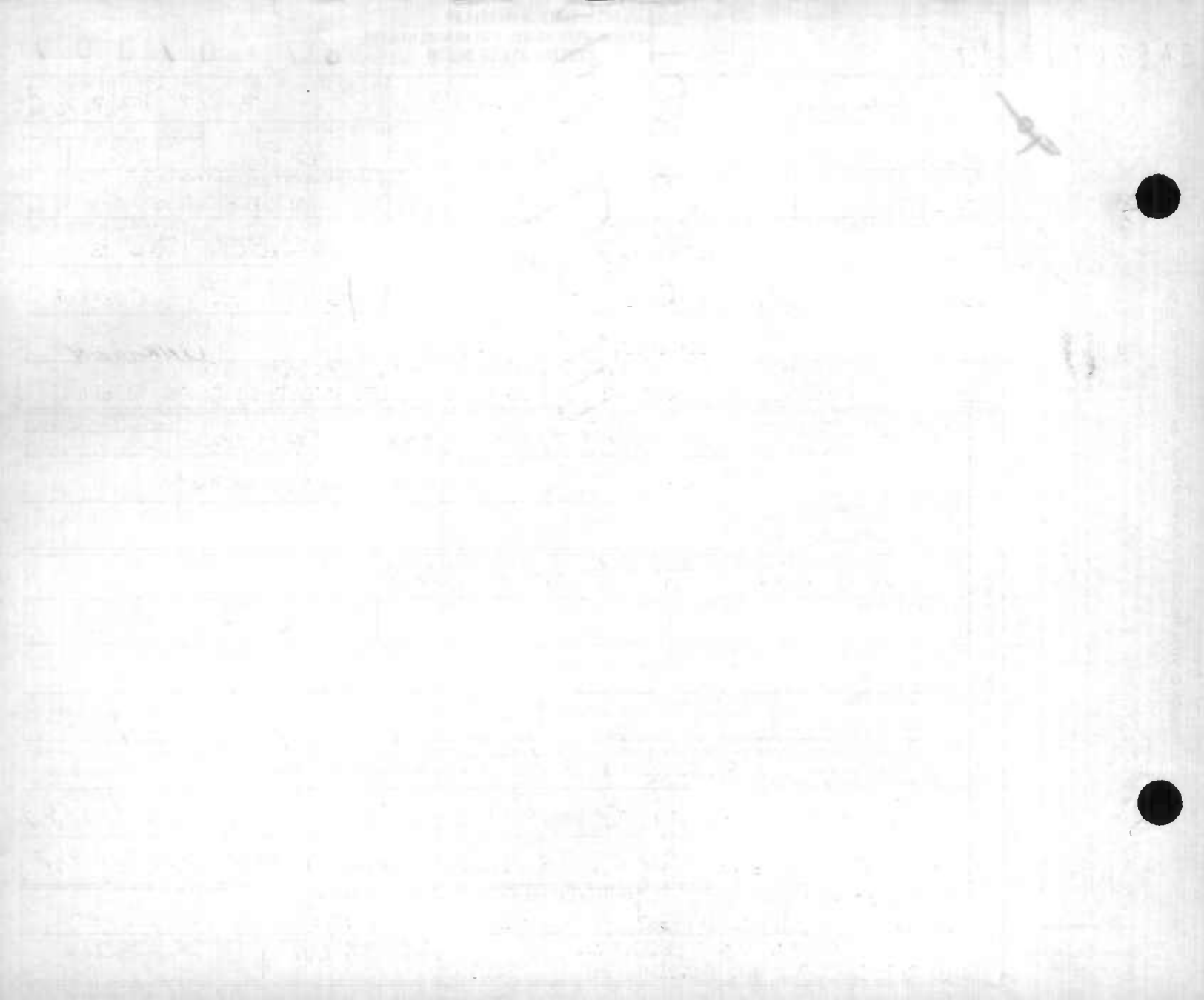
Very truly yours,
[Illegible signature]
[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) PHILIP PAUL SCHWARTZ | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 17 87 | | | | | 2b. HOUR
3.10^{AM} | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 17 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
N. CHARLES GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PROPRIETOR | | 12b. KIND OF BUSINESS OR INDUSTRY
FABRICS | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13e. STREET ADDRESS / ZIP CODE | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
OWINGS MILLS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20 CORNBURY CT. | | #21117 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JACK SCHWARTZ | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GUSSIE UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII-ARMY 083-07-4575 | | 17. INFORMANT MRS. FERN B. TRAVIS
20 CORNBURY CT. OWINGS MILLS, MD 21117 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) ISCHEMIC CARDIOMYOPATHY | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
RENAL INSUFFICIENCY | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/5 , 19 87 , to 3/17 , 19 87 , that (I) (we) last saw the deceased alive on 3/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
AmBACH WORETA MD | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AMBACH WORETA | | | | 22e. ADDRESS
NORTH CHARLES HOSP. BALTO, MD. | | | | | | | |
| 23a. BURIAL, CREMATION OR REMOVAL
(SPECIFY) BURIAL | | | | 23b. DATE
MAR. 19, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH DAVID | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ELMONT LONG IS. NY | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS. INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD | | | | | | 25. DATE REC'D BY REGISTRAR
MAR 24 1987 | | 26. REGISTRAR'S SIGNATURE
Jane Gordon-Randall | | | |



049927 APR 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07810
REG. NO.

| | | | | |
|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Scott Baby Girl | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 3 87 | | 2b. HOUR
1430 M |
| 3. SEX
Female | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
3 3 87 | | 6. AGE (IN YEARS-LAST BIRTHDAY)
YEARS MONTHS DAYS
35 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
B. Cit MD |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)
St Agnes Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
5870 St Agnes Forest Rd |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Valencia Lynn Scott | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Valencia Lynn Scott | | 16. ADDRESS
5870 St Agnes Forest Rd Baltimore, Md | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO.
27043 | 17. INFORMANT
Valencia Lynn Scott | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature 19WK by exam
DUE TO, OR AS A CONSEQUENCE OF (b) R/O chromosomal anomalies
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
James E Taylor | DEGREE
M.D. | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
3/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES E TAYLOR | 22e. ADDRESS
ST. AGNES HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
3/26/87 | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. 21229 | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD Funl Home, 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
APR 07 1987 | | |
| BALTIMORE, MD. 21229 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all signatures, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP

20% COTTON FIBRE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

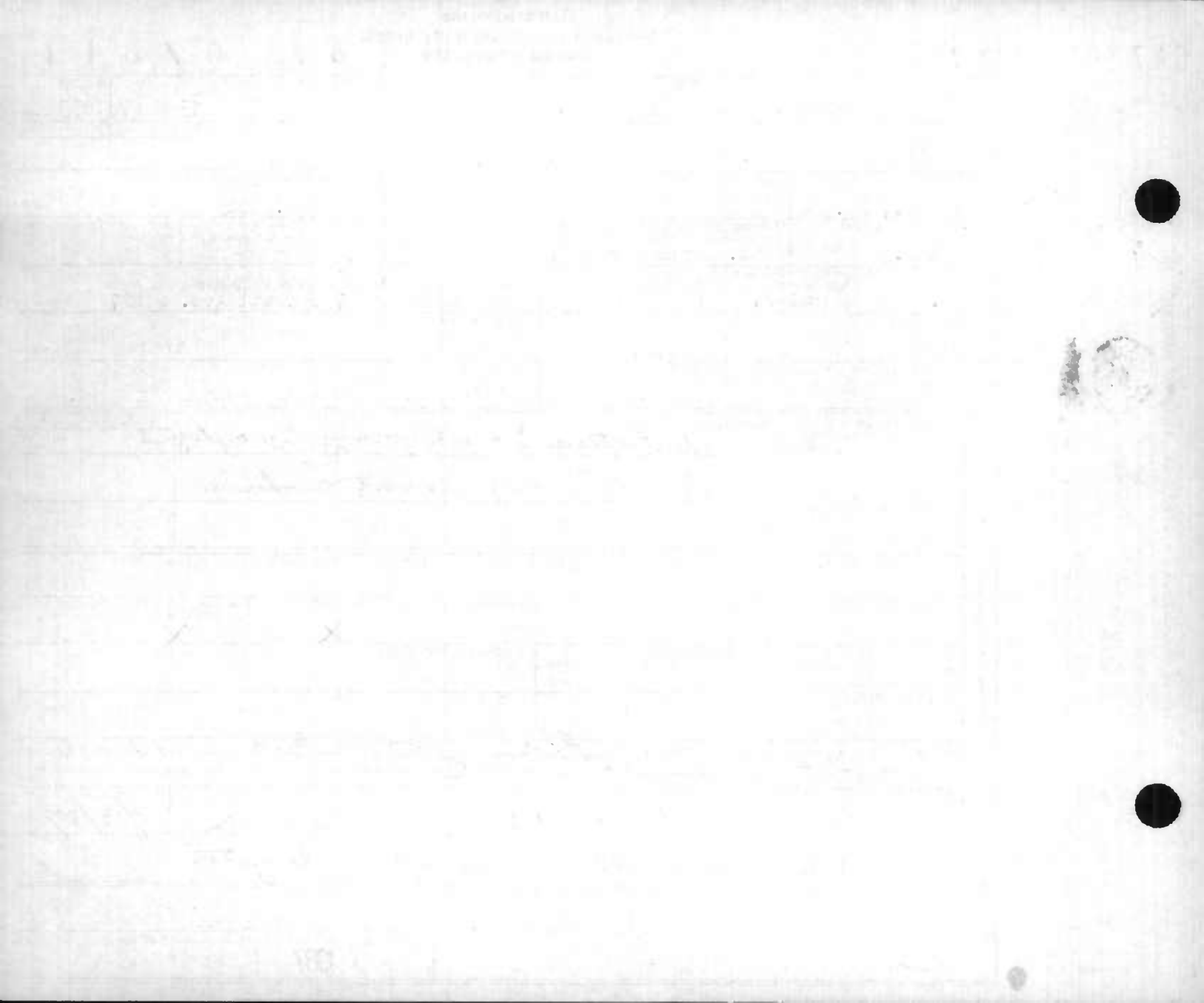
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3 and 4 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|---------------------------------------|---|--|
| FOR STATE REGISTRAR | | | | | 87 07811
REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST
CLARENCE RANDALL SCOTT | | | | | MONTH DAY YEAR HOUR
03 13 87 1035 A.M. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Male | | Black | | MONTH DAY YEAR
09 18 40 | | 46 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Balto., Md. | | | | | | Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | | St. Agnes Hospital | | | | Unemployed. | | | |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | | |
| Md. | | | | | Baltimore | | 7 Garrett Ave. 21227 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST
James Scott | | | | | FIRST MIDDLE LAST
Mary Foster | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS (21227) | | |
| No | | | | | 216-36-3781 | | Sylvia Brown 1107 Sulphur Springs Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intrathoracic + pulmonary hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholic liver disease + cirrhosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> 19 <u>87</u> to <u>3/13</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>William J. Hicken MD</u> | | MD | | | | | | <u>3/13/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| <u>WJM J HICKEN MD</u> | | | | | <u>St Agnes Hospital</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | 3/17/87 | | Arbutus Mem. Cem. | | Arbutus Md. | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>W. C. March F/H 4300 Wabash Ave.</u> | | | | | | <u>7 1987</u> | | <u>W. C. March</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

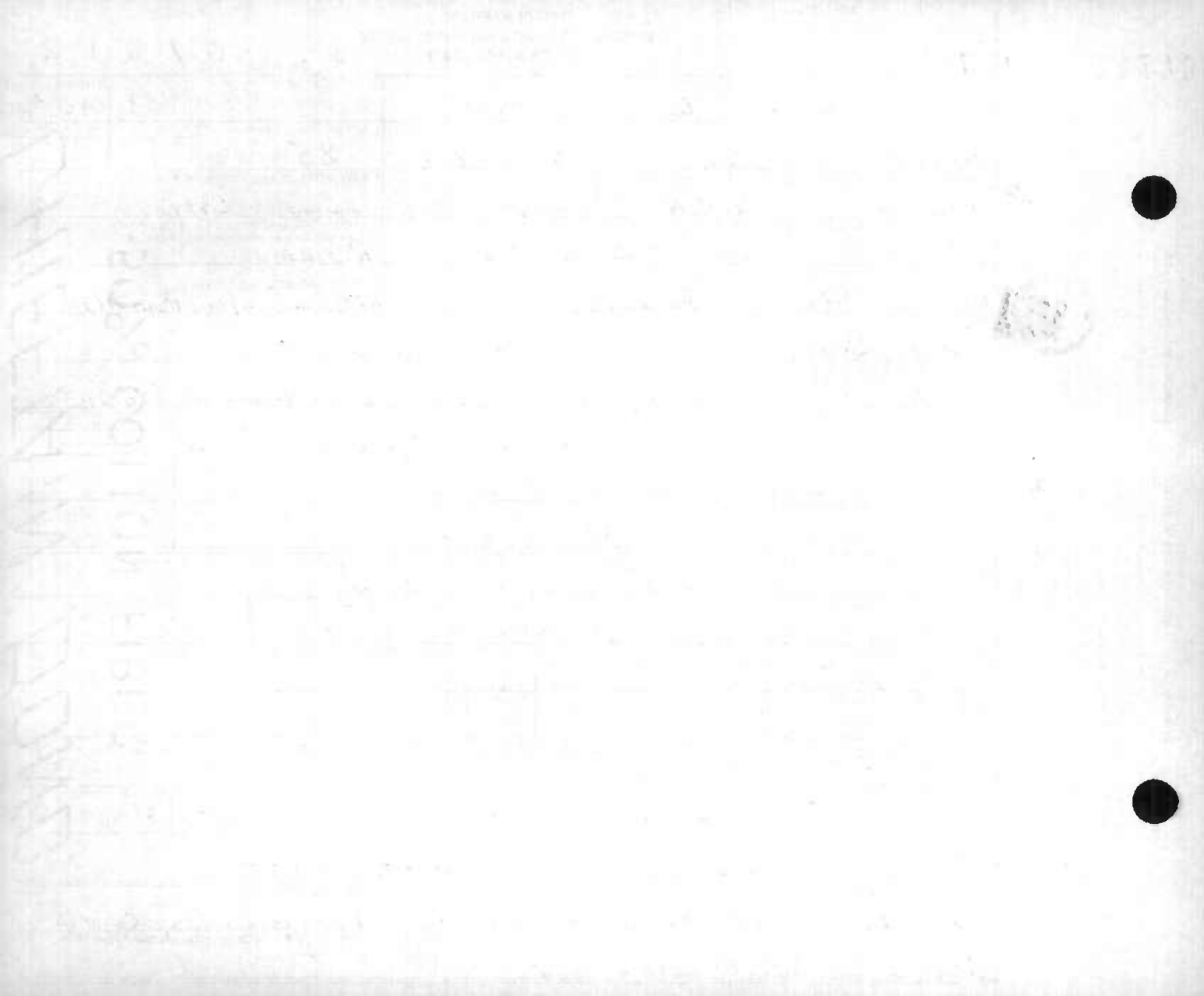
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the county after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07812
REG. NO.

| | | | | | | | | | | | |
|--|------------------------------|---|--------|--|---|---|---|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| COLUMBUS W. SCOTT | | | | | 3 11 87 | | | | | 0200A ^M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| MALE | Col | 1-9-02 | | | 85 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| VIRGINIA | U.S.A. | | | | BALTIMORE City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE CITY | | UNION MEMORIAL HOSPITAL | | | | RETIRED | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| MARYLAND | | BALTIMORE | | BANDOLLA TOWN | | 13e. STREET ADDRESS / ZIP CODE
4830 OAKLAND PARK ROAD 21133 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| JOHN SCOTT | | | | ANNA ROGERS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 215 09 2642 | | Mrs RUTH SCRIBNER 4830 OAKLAND PARK RO 21133 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Intermittent myocardial Infarction</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
8 hours | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe Anemia</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Bladder Tumor</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Disseminated Intravascular Coagulopathy</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | |
| 3/11/87 | | PAINLESS Hematuria | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>87</u> , to <u>3/11</u> 19 <u>87</u> , that (I) (we) last
saw the deceased alive on <u>3/11</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| | | | | MD | | | | 3/11/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| S.O. Trerotola MD | | | | UNION MEMORIAL HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | |
| BURIAL | | 3-16-87 | | St THOMAS Cem | | BANDOLLA TOWN | | BALTO Co | | MD | |
| 24. FUNERAL DIRECTOR
NAME | | | | 24b. ADDRESS | | | | 25a. DATE REC'D BY BUREAU (STRAT) (25b. REGISTRAR'S SIGNATURE) | | | |
| JOSEPH L. RUSS 2222 W. NORTH AVE | | | | | | | | MAR 17 1987 | | | |

BP _____



047633 MAR 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 07813

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Thomas Scott | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 17 87 | | | 2b. HOUR
4:00 PM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 30 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2307 Grove Street | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Store Propretor | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Emp. | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
2307 Grove Street 21230 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter David Scott | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Roxie Phillips | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
227-12-3250 | | 17. INFORMANT
ADDRESS
Ruth Rhodes 2611 Georgetown Rd. 21230 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> , 19 <u>85</u> , to <u>2/19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>CD Kearney MD</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/18/87</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Christopher D. Kearney, MD. | | | | | | 22e. ADDRESS
700 Washington Blvd. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/20/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. pK. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>John P. Anderson</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, it may be retained by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical certificate must be notified of one.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 07814
REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John Seato | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3-31-87 | | | |
| 3. SEX Male | | | | 2b. HOUR 8:19 PM | | | |
| 4. RACE WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR 8 14 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON MED. CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) LONGSHOREMAN | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST THOMAS SEATO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST MARY JANUCK | | 13e. STREET ADDRESS / ZIP CODE 720 S. BETHEL ST. / 21237 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) — | | 16b. SOCIAL SECURITY NO. 217-07-9983 | | 17. INFORMANT ADDRESS CASIMIR J. SEATO / 1911 ELLINWOOD BL. 21237 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastric Carcinoma with small bowel metastases.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Dehydration | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 26 , 19 87 , to March 31 , 19 87 , that (I) (we) last saw the deceased alive on March 31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
George Taler, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4/1/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Taler, M.D. | | 22e. ADDRESS 600 Light St. Baltimore, MD. 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 4-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY BALTIMORE COUNTY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE MD. | |
| 24. FUNERAL DIRECTOR
NAME LILLY + ZEILER, INC. | | ADDRESS 1901 EASTERN AVE | | 25a. DATE REC'D. BY REGISTRAR APR - 3 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

4/9

Baltimore City

U.S.A

2 CARLINA

RECEIVED DEPT. OF HEALTH

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RECEIVED DEPT. OF HEALTH

4-27

4-27

LILLY + ZILBER, INC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 87 07815 | |
|---|--|--|--|---|--------|---|----------------------------------|--|----------|--|--|
| 1. FOR STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | |
| | | LINDA L SEMANS | | | | | FEBRUARY 28, 1987 | | 6:45P M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| Female | | White | | May 10, 1947 | | 39 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U S | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | | | Home Maker | | Same | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE | | | | | |
| Del. | | Kent | | Dover | | 76 Asbury Ave. 99999 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Jerome S. Meyd | | | | Peggy North Meyd | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | No | | 214-48-1951 | | Neal H. Semans 76 Asbury Ave. Dover, Del. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Cardiovascular Failure | | | | | | | | | | 12 hours | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension and Sepsis | | | | | | | | | | 38 hours | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hepatic Artery Thrombosis and Liver Transplant | | | | | | | | | | 38 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 2-16-87 | | Hematomy | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-16-87 to 2-28-87, that (I) (we) last saw the deceased alive on 2-28-87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 27a. SIGNATURE | | | | DEGREE | | | | 27c. DATE SIGNED | | | |
| John R. Roberts | | | | M.D. | | | | 2-28-87 | | | |
| 27b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 27d. ADDRESS | | | | | | | |
| John R. Roberts | | | | 600 N. WOLFE ST | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | March 5, 1987 | | Barretts Chapel | | Frederica, Kent Del. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE PREP. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Thomas R. Traders | | | | 12 Lotus St Dover Del | | | | MAR 13 1987 Julia Anderson-Randall | | | |



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WASH

MAR 18 1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or a violent event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07810 | |
|--|--|--|--|---|---|--|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
PATRICIA L. SERRA | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 2, 1987 | | | 2b. HOUR
7:05A _M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
OCT. 10, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1536 E. COLD SPRING LANE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
DENTAL | | | |
| 13a. STATE
MARYLAND | | 13b. CITY OR TOWN
21218 | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
1536 E. COLD SPRING LANE 21218 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN R. LARKIN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ALMA ANDREW | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
212-30-2470 | | 17. INFORMANT ADDRESS
LAWRENCE SERRA BALTIMORE, MD 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Pancreas</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Thrombocytopenia 2-3 weeks</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>Aug 24</u> , 19 <u>87</u> , to <u>Feb 14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Feb 14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Lawrence Mills</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/2/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LAWRENCE MILLS, M.D. | | | | 22e. ADDRESS
SUITE #103
GOOD SAMARITAN PROFESSIONAL BLDG. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK)
CREMATION | | 23b. DATE
MARCH 4, '87 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM E. JOHNSON | | | | ADDRESS
8521 LOCH RAVEN BLVD. | | 25a. DATE REC'D. BY REGISTRAR
MAR 02 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>John A. Smith</u> | | | |

BP



049136 APR - 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO.

07817

| | | | | | | | |
|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BERTHA SHACKLEFORD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 28 87 | | | 2b. HOUR
12:30 M | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 01 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Barto MD. | |
| 10. CITY OR TOWN OF DEATH
BARTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Barto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 12b. STREET ADDRESS / ZIP CODE
3423 Reisterstown Rd. 21215 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Brenda Mallory 3423 Reisterstown Rd | | | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **THALAMIC HEAVY ALCOHOL**

DUE TO, OR AS A CONSEQUENCE OF

(b) **HYPERTENSION**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **ARRYTHMIA**

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. J. Davis | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AJ Davis | | 22e. ADDRESS
5000 BALTO. NATL. PIKE BALTO. MD 21229 | | | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
4-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. Zion com | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Landsdown MD. | |
| 24. FUNERAL DIRECTOR
NAME BROWN-THOMPSON ADDRESS 1913 W. BALTO. ST. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 1 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top portion of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

046681

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07818

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PAUL MICHAEL SHANDOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 8, 1987 | | 2b. HOUR
2:00 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
January 29, 1954 | 6. AGE (IN YEARS LAST BIRTHDAY)
33 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education |
| 13a. STATE
Pennsylvania | | 13b. COUNTY
Cambria | 13c. CITY OR TOWN
Vintondale | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul --- Shandor | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth --- Kosta | | 16. STREET ADDRESS / ZIP CODE
Box 224, # 15961 99999 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No ----- | | 16b. SOCIAL SECURITY NO.
189-44-9423 | | 17. INFORMANT WIFE: ADDRESS
Elizabeth Shandor, Box 224, Pennsylvania Vintondale, #15961 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hodgkin disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>hepatic vein occlusive disease</u>
Approximate interval between onset and death
<u>2 weeks</u>
<u>7 years</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>hepatic vein occlusive disease</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>04/10/87</u> to <u>03/08/87</u> , that (I) (we) lost
saw the deceased alive on <u>02/03/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>M. Nasir</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/08/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MOHAMMAD NASIR | | 22e. ADDRESS
86 Rambley Oaks Way, BALT. MD. 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12 March 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Charles Ch. Cem | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Blacklick, Cambria, Pennsylv | | 24. FUNERAL DIRECTOR
NAME
Martin D. Lawson | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Denton-Rodgers | | | |



48497 MAR 30

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / REG. NO. 07819

| | | | | | | | | | | | |
|--|--|---|--|---|--|--------------------------------------|--|---|--|----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MILDRED | | MIDDLE G. | | LAST SHEPP | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR A | |
| | | | | | | | | MARCH 23, 1987 | | 1:29M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | June 11 1924 | | 62 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | BALTIMORE CITY | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | Retired Teacher | | Education | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| | | W. Va. | | Mineral | | Keyser | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 35 "A" Street 99999 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | |
| Chester C. Benson | | Lottie I. Bishop | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| Yes | | WW II | | 220-16-6455 | | Jeannette Heckman | | 41 "A" Street | | Keyser, W. Va. 26726 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiopulmonary arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 minutes

DUE TO, OR AS A CONSEQUENCE OF

acute renal failure

1 week

(b)

DUE TO, OR AS A CONSEQUENCE OF

adenocarcinoma of endometrium

3 months

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

acute renal failure, malignant ascites, pulmonary embolism

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10 19 87 to 3/22 19 87, that (I) (we) last saw the deceased alive on 3/22 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| <i>Matthew R. Kuntz</i> | | MD | | 3/22 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| MATTHEW R. KUNTZ | | 661 N. Wolfe Street Bal Md. | | | | | |

| | | | | | | | |
|--|--|-------------------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | 3/26/87 | | Oliver's Grove Cemetery | | Oldtown Allegany Md. | |
| 24. FUNERAL DIRECTOR
NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Markwood-McKenzie Funeral Home | | 111 S. Mineral Keyser, W. Va. | | MAR 27 1987 | | <i>John D. ...</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

7 225 69 53

TO HOSPITAL OR ATTENDING PHYSICIAN: The low-jars SHEPP the death certificate is received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the correct position in the death certificate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

BP

DHW: 10:00M 7/84
(VRA 10, 4)

14921 . 111

048868 APR - 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 27 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---------|--|------------------|---|---|---------------------------------------|---|-----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Bentha | | T. | S | Heppard | 3/29/87 | | | | | 12N M |
| 3. SEX | F | 4. RACE | B | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| | | | | MONTH DAY YEAR | 82 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| USA | USA | | | | BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | FEDERAL HILL | | | | Retired | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21230 | | | |
| 13b. COUNTY | | | | | 13c. CITY OR TOWN | | Federal Hill Nursing Home | | | |
| Md | | | | | None | | Balti. | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | |
| Unknown | | | | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | | 219-05-7832 | | Ester Taylor, 3806 Hayward Ave. 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>ARMY TRAUMA</u> | | | | | | | | | | |
| (c) <u>ASCVD</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/6/87</u> 19 <u>87</u> , to <u>3/30</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/6/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | | 22c. DATE SIGNED |
| <u>[Signature]</u> | | | | | MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 3/30/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| MARK DAVIS | | | | | 907 BALTIMORE AVE E C MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | 4/3/87 | | East View Mem. Pk | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS | | | | | MAR 31 1987 | | <u>[Signature]</u> | | | |
| Law Funeral Home 4611 Park Heights Ave. | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be essential - this 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or voluntarily filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 07821
REG. NO. | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE L. SHEPPERD | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 25, 1987 | | | | 2b. HOUR
PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 21, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MONKTON, MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5207 YORK RD. APT C-1 21212 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
PAINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME REPAIR | |
| 13a. STATE
MARYLAND | | | | 13b. CITY OR TOWN
BALTIMORE | | 13c. STREET ADDRESS / ZIP CODE
5207 YORK RD. APT C-1 21212 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WILMER D. SHEPPERD | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY ALICE WATSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
W.W. II 215-18-2341 | | 17. INFORMANT ADDRESS
W. THOMAS SHEPPERD BELAIR, MD 21014 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Dis.</u> S/P MI 1982
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>NA</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>NA</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<u>NA</u> | | | | | |
| 21d. INJURY OCCURRED <u>NA</u>
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u>NA</u> | | 21f. LOCATION STREET
CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13, 1983</u> to <u>March 26, 1987</u> , that (I) (we) last saw the deceased alive on <u>Jan. 29, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Bannister Lee Raines M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>3-26-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BANNISTER LEE RAINES, M.D. | | | | 22e. ADDRESS
5225 YORK ROAD 21212 433-3900 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MARCH 28, 87 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME
WILLIAM E. JOHNSON | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Tidwell-Randall</u> | | | |

Y. S. CHEN AND S. H. CHEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|------------------------------------|---|---|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a DATE OF DEATH | | | 2b HOUR | | | |
| FIRST MIDDLE LAST
MICHAEL Dan SHIPLEY | | | MONTH DAY YEAR
3 14 87 | | | 9:04A M | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b IF UNDER 1 YEAR | |
| Male | | White | | MONTH DAY YEAR
11 06 55 | | 31 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Sinai Hospital | | | | Electrician-Edwin | | Miller Elec.Co. | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b COUNTY | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS / ZIP CODE | | | |
| MD | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 215 Lincoln Ave | | 21043 | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST
Guy S. Shipley, Jr. | | | FIRST MIDDLE LAST
Mary D. Dugan | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | |
| Yrs | | | Vietnam | | 217-64-2777 Mary D. Shipley, same as #13e | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Respiratory (cardiac arrest) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b) anoxic encephalopathy | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) drug overdose | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 2 12 87 | | Subject used drugs-UNDETERMINED MANNER | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]
unknown | | STREET CITY OR TOWN COUNTY STATE
Unknown Md. | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 2-12-87 to 3-14-87, that (I) saw the deceased alive on 3-14-87, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| TREDUP | | M.D. | | | | 3-14-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | |
| | | Sinai Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | | |
| Cremation | | 3-16-87 | | Westview Crematory | | Baltimore, Maryland | | | |
| 24 FUNERAL DIRECTOR | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| NAME Ruck Towson Funeral Hoke, Inc. ADDRESS Towson, Md. 21204 | | | | 1050 York Rd. | | MAR 17 1987 Julia Davidson-Randall | | | |

BP

100-100-100

100

100-100-100

100-100-100

100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit requires carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MARY | | MIDDLE Spaid | | LAST Short | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | MONTH DAY YEAR
4 13 32 | | 54 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PA. | | USA | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | 9000 SAMARITAN HOSPITAL | | nurse | | nursing | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| | | MD | | Carroll | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 342 Kees Mill Rd. 21784 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | |
| George A. Spaid | | Gertrude Arbogast | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17 INFORMANT ADDRESS | | | | | | | |
| no | | na | | 208-24-2728 H. James Short, 13e | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GRANULOCYTOPENIA / Toxicity of Tumors
DUE TO, OR AS A CONSEQUENCE OF
(b) Chemotherapy for Metastatic Breast Cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/18, 19 87, to 3/30, 19 87, that (I) (we) last saw the deceased alive on 3/30, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | 22c. DATE SIGNED | | | |
| Michael Chart | | | | | | | | 3/30/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Michael Chart | | 5601 Loc L Rary, BALTIMORE, MD, 21239 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Cremation | | 3/31/87 | | Carroll Crematory | | Hampstead Carroll MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert K. Pritts, Sr., Westminister, MD | | APR 03 1987 | | | | | | Julia Devision-Randall | | | |

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4/14

APR 03 201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

047643 MAR 1987

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07824
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
LUCILLE WRIGHT SHORTS | | 2a. DATE OF DEATH MONTH DAY YEAR
03 14 87 | | 2b. HOUR
8:55 AM | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
11 03 1904 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Saint Agnes Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CATERER/COOK | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF-EMPLOYED | | 13a. STREET ADDRESS / ZIP CODE
BALTO. MD.
331 S. ELLAMONT ST. / 21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
REV. WILLIAM WRIGHT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
EDITH AUSTIN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
214-18-5906 | | 17. INFORMANT MR. TYRONE KELLY | | BALTIMORE, MD. 21229
331 S. ELLAMONT ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Respiratory Failure / Arrest
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Lower GI Bleeding | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 02/26/1987, 1987, to 03/14, 1987, that (I) (we) last saw the deceased alive on 3/14/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Sabah Ali Al-Attar, M.D. | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
03/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sabah Ali Al-Attar | | 22e. ADDRESS
Saint Agnes Hospital, Balt. MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/19/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTERN STAR CEM. | |
| 23d. LOCATION CITY OR TOWN
BALTIMORE, MD. | | 23e. COUNTY | | 23f. STATE | |
| 24. FUNERAL HOME NAME
Nutter + Sons Funeral Home, Inc.
2501 Gwynns Falls Pkwy, BALTO, MD. 21216 | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE | |

11-21-30

TO: Mr. J. H. ...
FROM: Mr. ...
SUBJECT: ...
RE: ...

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...
...
...
...



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...
...
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. These pages must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07825 | |
|---|--|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
SAM S. SICA | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 14 87 | | | 7b. HOUR
1 ¹² A M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
1-30-1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 yrs. YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT PLACED IN CARE, GIVE STREET ADDRESS)
UNIVERSITY HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Cleaner & Presser | | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Employe | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4905 Willshire Avenue 21206 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Vincent Sica | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rosario Giordana | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
YES | | 16b. SOCIAL SECURITY NO.
W11 220-14-0513 | | 17. INFORMANT ADDRESS
Mildred Sica 4905 Willshire Avenue 21206 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1/22/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CORONARY ARTERY DISEASE | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22/87, 19, to 3/14/87, 19, that (I) (we) lost saw the deceased alive on 3/14/87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert Applebaum MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/14/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT APPLEBAUM | | | | 22e. ADDRESS
22 S GREEVE ST. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | 23b. DATE
3-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | |
| 24. FUNERAL HOME
NAME ADDRESS
Schumaker Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
MAR 17 1987 | | | |

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PI 87-47-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The following death certificate is associated with 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 through 4 may be filed in the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JAY Siegel | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03-10-87 | | | 2b. HOUR
10 50 AM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 17 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Levinvale Nsg Home | | | | 12a. USUAL OCCUPATION
(HOUSEWIFE IF WORKING LIFE)
homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | |
| 13a. STATE
Md | | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES XXX NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MAX GOLDSTEIN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PAULA UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 16b. DATE OF ENTRY TO U.S. ARMY
(IF YES, GIVE WAR OR DATES)
089207-0367
XXXXXX 8747 | | 17. INFORMANT
ADDRESS
XXXXXX ELI SIEGEL 6839 PARSONS AVE. 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTICEMIA
DUE TO, OR AS A CONSEQUENCE OF
(b) RECURRENT ASPIRATION PNEUMONIA IN W
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
29 hrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-25-87 to 3-10-87, that (I) (we) last saw the deceased alive on 3-10-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | DEGREE | | | 22c. DATE SIGNED
3-10-87 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. ZAW-WIN, MD | | | 22e. ADDRESS
Levinvale Geriatric Ctr 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
3/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY
RUDOMER VEREIN CEM | | 23d. LOCATION
ROSEDALE CO BALTO MD | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS, INC.
6010 REISTERSOTWN R. BALTO, MD 21215 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |

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ADAMSIDE ROAD, N. 1, E. 1

ADAMS PLANT-01-101 121

ADAMS PLANT-01-101 121

ADAMS PLANT-01-101 121

ADAMS PLANT-01-101 121

047289 MAR 17

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 07827

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--------------------------------|--|---------------------|--|--------------------------------------|--|----------|--|----------|--|------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| WILLIAM | | M. | | SIEJACK | | | | X | | 3 | | 14 | | 19 | | 87 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| MALE | | CAUC. | | 3 - 27 - 12 | | 74 YRS. | | | | | | 3 | | 14 | | 19 | | 87 | | 3:20 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | X NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| MARYLAND | | U.S.A. | | | | | | | | | | Baltimore City | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | 630 S. Belnord Ave. | | RETIRED | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| MARYLAND | | | | BALTIMORE | | YES X NO | | 630 S. BELNORD AVE. 21224 | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | | | | | |
| FRANK | | | | | | SIEJACK | | ANNA | | | | | | MICHALAK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| NO | | | | 216-03-5681 | | MRS. EVE SIEJACK | | 21224 630 S. BELNORD AVE. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Arteriosclerotic cardiovascular disease | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | (b) | | | | | | | | | | | | | |
| | | | | | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | |
| | | | | YES NO X | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: | | Natural causes X Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | | | |
| | | M.D. Assistant MEDICAL EXAMINER | | 3-14-87 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | William M. Zane, M.D. | | ADDRESS | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | | | | | |
| ENTOMBMENT | | 3/18/87 | | ST. STANISLAUS CEM. | | BALTIMORE, MARYLAND | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| | | | | | | MAR 16 1987 | | | | | | | | | | | | | | | |
| KACZOROWSKI FUNERAL HOME 2525 FLEET ST. | | | | | | | | | | | | | | | | | | | | | |

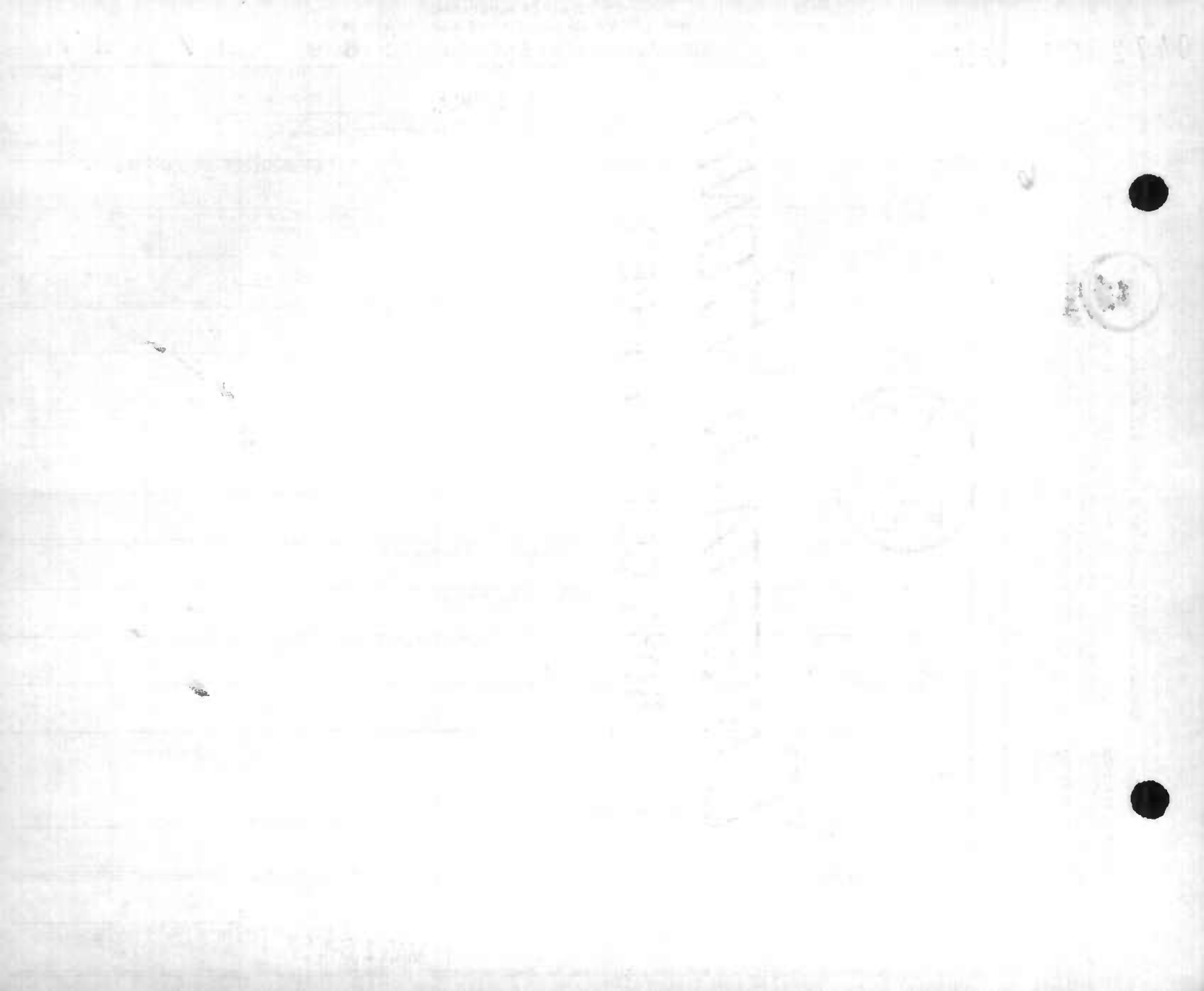
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PMA-100. IN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

BP

DHMH - 17
(VR A15 ME (5))



48857 APR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07828

| | | | | | |
|--|---------|---|-------------------|--|---------------------|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE ESTIMATED | | 2d. HOUR | |
| EUNICE | | 3-23-87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 7. IF UNDER 24 HRS. |
| FEMALE | WHITE | AUG. 23, 1927 | 59 YRS. | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| MARYLAND | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | 3516 Labyrinth Rd. C1 | | BOOKKEEPER | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. APT. IC | |
| PHILLIP | | SOPHIE | | GERTZ | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 218-22-4515 | | MR. STEVEN Z. ROSENSWEIG | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. SOCIAL SECURITY NO. | | 20. HOUSTON, TX | |
| PART I DEATH WAS CAUSED BY: | | 218-22-4515 | | 6111 WILLOWBEND APT. 702 HOUSTON, TX | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Margarita A. Korell, M.D. | | Assistant MEDICAL EXAMINER | | 3-26-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Margarita A. Korell, M.D. | | 111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | MAR. 27, 1987 | | CHIZUK AMUNO | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS., INC. | | MAR 31 1987 | | | |
| 6010 REISTERSTOWN RD. BALTO., MD | | 21215 | | | |

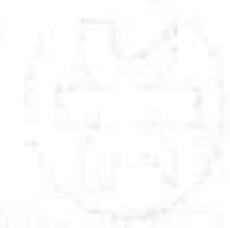
07/84
25MBP
DHMH - 17
(VR A15 ME (5))

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8707829 | |
|--|--|---|--|---|-------------------|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| Mr. Donald Lee Simmons | | | | | March 7 1987 | | | | | 6:12 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | CAUCASIAN | | January 30 1923 | | 64 | | MONTHS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED, <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | United States | | | | Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Francis Scott Key Medical Center | | | | Retired Laborer | | Baltimore City | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | 13f. ZIP CODE | |
| Maryland | | Baltimore | | Essex | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 490 Mirabile Lane | | 21224 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Robert Simmons | | | | Louise Buckingham | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INMARRIED | | ADDRESS | | 17a. CITY | | 17b. STATE | |
| yes | | WW II | | 217-18-1332 | | Mrs. Edith O. Simmons | | 490 Mirabile Lane | | Baltimore Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Out Cell Carcinoma Lung</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | STREET | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 5</u> 19 <u>87</u> , to <u>March 7</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>March 7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <u>Robert F. Committ</u> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 3-7-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| <u>Robert F. Committ</u> | | | | <u>4940 Eastern Avenue Beltsville, MD</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | 3/11/87 | | Lake View Mem. Park | | Sykesville Carroll Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD. 21133 | | | | | | MAR 10 1987 | | <u>Julia F. ...</u> | | | |

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1

MAY 10 1961

046687

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07830
REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT C SIMMONS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/5/87 | | 2b. HOUR
3:36 P.M. |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
02 20 46 | | 6. AGE (IN YEARS LAST BIRTHDAY)
41 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
Designer | 12b. KIND OF BUSINESS OR INDUSTRY
Florist | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Baltimore | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
436 Simmons Ave. 21224 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LeRoy L. Simmons | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Schenton | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218 42 1880 | | 17. INFORMANT ADDRESS
2401 Rochell Dr. Fallston Md 21047 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) CARDIOMYOPATHY
DUE TO, OR AS A CONSEQUENCE OF
(c) ALCOHOLISM | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
2 YEARS
20 YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
POSSIBLE SEPSIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that on this hospital attended the deceased from 3/5 to 3/5 19 87 , that I saw the deceased alive on 3/5 19 87 , and that in my opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.) | | | | | |
| 22b. SIGNATURE
Lois E. Nielsen | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/5/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LOIS E. NIELSEN | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
3/7/87 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co., Md. |
| 24. FUNERAL DIRECTOR'S
Brazdzinski Funeral Home PA 1407 Old Eastern Ave 21221 | | | 25a. DATE REC'D. BY REGISTRAR
MAR 10 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
Lois E. Nielsen | | | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. It also carries more carbon copies. Pages 4 and 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene. It is important that the certificate be filled in by the funeral director or the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 above only apply, or other traumatic event, the medical examiner may be notified instead.

BP

1. The first section of the report discusses the current state of the project and the progress made since the last meeting. It highlights the challenges faced and the strategies implemented to overcome them.

2. The second section provides a detailed analysis of the data collected during the field research. It includes statistical summaries and graphical representations to illustrate the findings.

3. The third section discusses the implications of the research findings for the broader field of study. It compares the results with previous research and offers insights into potential future directions.

4. The final section concludes the report by summarizing the key points and reiterating the importance of the research. It also includes a list of references and a bibliography.



5. The following section details the methodology used in the study, including the selection of participants, the design of the experiments, and the data collection procedures.

6. The next section presents the results of the experiments, showing the mean values and standard deviations for each condition. It also includes a discussion of the statistical significance of the findings.

7. The final section of the report discusses the limitations of the study and the potential for future research. It suggests ways in which the study could be expanded or replicated to further explore the research questions.

8. The report concludes with a final summary of the findings and a statement of the author's appreciation for the support and assistance provided during the research process.

047897 MAR 25 1987

Film G626 item 5,6,

FOR
STATE 4/15/87 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07831

| | | | | | | | | | | | | | |
|---|--|---------|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | | 2b. HOUR | |
| Samuel Patrick Simmons | | | | | | | | XX 3-9 1987 | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
- LAST BIRTHDAY) | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| Male | | White | | Jan 90 1915 | | 15 YRS. | | | | 3-9 1987 | | 1:35 p. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| West Virginia | | | | U.S.A. | | | | | | | | Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | | University Hospital - STU | | | | Utilities, Public Wks. | | | | Public Works | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | |
| Maryland | | | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20801 York Road /21120 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| Isaac Simmons | | | | May Childress | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| yes | | | | WW II | | 217-01-3891 | | | | Hallie I. Simmons, 20801 York Rd, Parkton MD 21120 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Gunshot Wound of Head (handgun) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| Cerebrovascular Hemorrhage | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| ? P.M. 3-9 1987 | | | | subject shot himself | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | home | | | | 20801 York Road, Cockeysville, Balto. Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on depth resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | |
| Dennis F. Smyth, M.D. | | | | Assistant | | | | 3-10-87 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | March 12, 87 | | Bosley United Meth. Cem. | | | | Sparks Baltimore MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| J.J. Hartenstein, 24 Second St, New Freedom, PA 17349 | | | | | | MAR 17 1987 | | Julia Tindem-Rudner | | | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A FURTHER PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRAVEL PERMIT PAGE 2 AND 7 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07832 | | | |
|---|--|--|--|--|--|--|--|--|---|---|-------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WINIFRED G. SIMMONS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR MARCH 2, 1987 | | | | | 2b. HOUR
12:37P | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR Sept. 8, 1915 | | | 6 AGE (IN YEARS LAST BIRTHDAY)
71 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Maintenance Co. | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Frederick | | 13c. CITY OR TOWN
Middletown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7301 Pin Oak Drive/21769 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alexander -- Gauld | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha -- Walker | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
ADDRESS
Vernon A. Simmons, Same address as #13. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 10 years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 minutes | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Thoracic Aneurysm | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11/3/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Thoracic Aneurysm | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 3, 1986 , to March 2, 1987 , that (we) lost
saw the deceased alive on March 2, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
J. W. Winston | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/2/87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. W. Winston | | | | | 22e. ADDRESS
Johns Hopkins Hospital | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Rahway Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rahway, New Jersey | | | | | | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc.
ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 06 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07833
REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|---|-----------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
BENJAMIN A SIMMS Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 28, 1987 | | | 2b. HOUR
10:20 ^M | | | | | |
| 3 SEX
M. | | 4 RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 25 61 | | 6. AGE (IN YEARS LAST BIRTHDAY)
25 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
HAR | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1840 Bowman Ct. 21401 | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Benjamin A. SIMMS SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Evans | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | | | 16b. SOCIAL SECURITY NO.
218-76-5541 | | 17. INFORMANT ADDRESS
Benjamin A. Simms, Sr 1840 Bowman Ct | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple cerebral lesions
DUE TO, OR AS A CONSEQUENCE OF
(b) immune deficiency
DUE TO, OR AS A CONSEQUENCE OF
(c) Retroviral Infection | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 mo
2 yr | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Mycobacterium avium-intracellulare infection | | | | | | | | | | | |
| 19a. DATE OF OPERATION
3-12-87 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Multiple cerebral lesions | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-24-87 to 3-28-87 that (I) (we) lost
saw the deceased alive on 3-27-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Andrew Vernon | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-28-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Vernon | | | | 22e. ADDRESS
600 N. WOLFE ST. BALTO., MD. 21205 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Vet | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville Md | | | |
| 24 FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 1 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rudack | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07834
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LOUISE SIMPKINS | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 17 87 | | 2b. HOUR
1:30 PM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3/6/15 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1716 W. Lanvale St. 21217 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Simpkins | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susie Simpkins | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Rose Yates 3922 Boarman Ave. | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
(b) CEREBRAL VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF senile dementia
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1/29 87 3/17 87 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/17 87 to 3/17 87 , that (I) (we) last saw the deceased alive on 3/17 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Kuang-yen Huang M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
03/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KUANG-YEN HUANG M.D. | | 22e. ADDRESS
BON SECOURS Hospital | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
3/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansdown A.A.C. Md. | |
|--|--|-----------------------------|--|--|--|--|--|

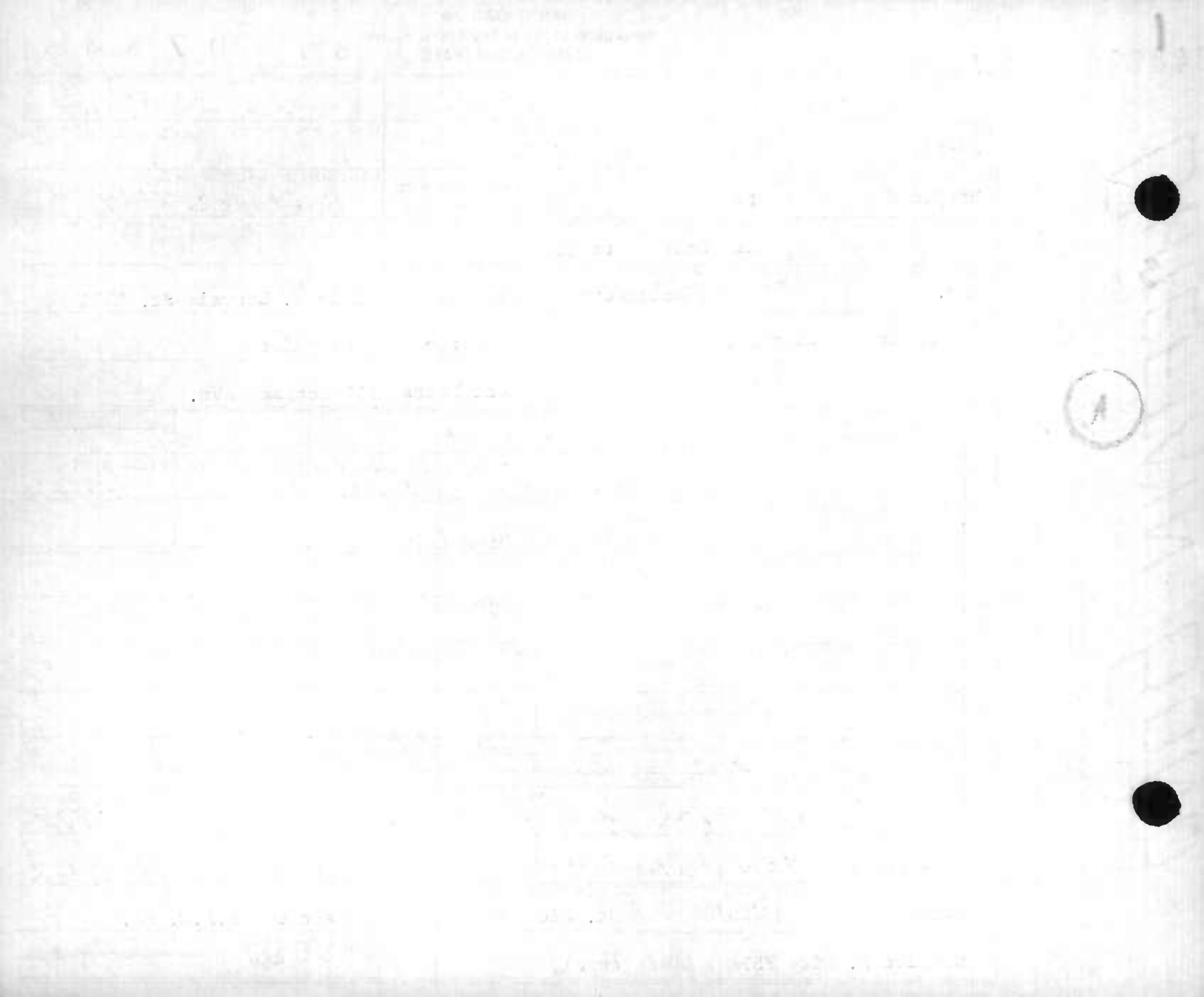
| | | | | | |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
Charles A. Rice FSPA 1300 Eutaw Pl, | | 25a. DATE RECEIVED BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Wm. Lansdown-Randall</i> | |
|--|--|---|--|---|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it can only be completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove transportation pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical certificate must be signed at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 07835

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|-------------------------|---|---|---|--------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) DONTAY SIMPSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-17-87 | | 2b. HOUR
4:37A |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
9 20 76 | | 6. AGE (IN YEARS LAST BIRTHDAY)
10 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. MD. MED. SYSTEM | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
1211 SHELLBANKS RD 21225 | |
| 13a. STREET ADDRESS / ZIP CODE | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
KEVIN SIMPSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GWENDOLYN GOODWIN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO.
216888570 | | 17. INFORMANT
GWENDOLYN GOODWIN | | ADDRESS
1211 SHELLBANKS RD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARDIOMYOPATHY
DUE TO, OR AS A CONSEQUENCE OF
(c) ACUTE LYMPHOCYTIC LEUKEMIA | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4/15 1984 to 3/17 1987 , that (2) we last saw the deceased alive on MARCH 17 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Allen D. Schwartz, M.D. | | DEGREE
MD | | 22c. DATE SIGNED
3/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALLEN D. SCHWARTZ | | 22e. ADDRESS
UNIV. MARYLAND HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-21-87 | | 23c. NAME OF CEMETERY OR CREMATORY
GEDAR Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNE ARUNDEL MD | | 23e. DATE REC'D. BY REGISTRAR
MAR 20 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME | | ADDRESS
1101 E. NORTH AVENUE | | 24b. REGISTRAR'S SIGNATURE
Julia Anderson-Badger | |

01010

DATE

10/10/10

CPRT



10/10/10

10/10/10

10/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the other persons designated completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-payers, pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

FOR
STATE
REGISTRAR

June Sisk

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 07835

| | | | | |
|---|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JUNE SISK | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 8 87 | | 2b. HOUR
11:31 P.M. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
6 09 21 | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen Hosp | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Home Maker | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MD | | 13c. CITY OR TOWN
GLEN BURNIE | 13d. STREET ADDRESS / ZIP CODE
172 MARGATE DR. 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Edwards | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA FRANK | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215183025 | | 17. INFORMANT
ADDRESS
Stonewall J. Sisk Same as 13c |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18/87, 1987, to 3/8/87, 1987, that (I) (we) lost
saw the deceased alive on 3/8/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/8/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS WOLFE | | 22e. ADDRESS
3001 S. Hanover Street | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Park |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md | | | | |
| 24. FUNERAL DIRECTOR
George J. Gonc 4001 Ritchie Hwy Balto Md | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Pandora |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|---|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
JOSEPH George SISOLAK, Sr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 24, 1987 | | | | | 2b. HOUR
5:10a M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
8 5 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital, Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Steamfitter | | | 12b. KIND OF BUSINESS OR INDUSTRY
Ship Const. | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Edgemere | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
8908 Hinton Ave./21219 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Emrich | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Angela Nemec | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215/09/4816 | | 17. INFORMANT ADDRESS
Balto., Md. 21219
Joseph G. Sisolak, Jr. 8907 Chesapeake Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE ORGAN FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) CANCER OF STOMACH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
DECEMBER 18, 1986 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CARCINOMA STOMACH | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
P.M. 19 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET
88 | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 17, 1986 to MARCH 24, 1987, that (I) (we) last saw the deceased alive on MARCH 24, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE
M. B. J. Puria | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
MAR. 24, 1987 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. BIJPURIA, MD. | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/26/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | | 23d. LOCATION CITY OR TOWN
Rosedale, Maryland | | STATE | | |
| 24. FUNERAL DIRECTOR NAME
Walter Brooks Bradley, Inc. | | | | ADDRESS
Balto., Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Borden-Rodgers | | | |



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

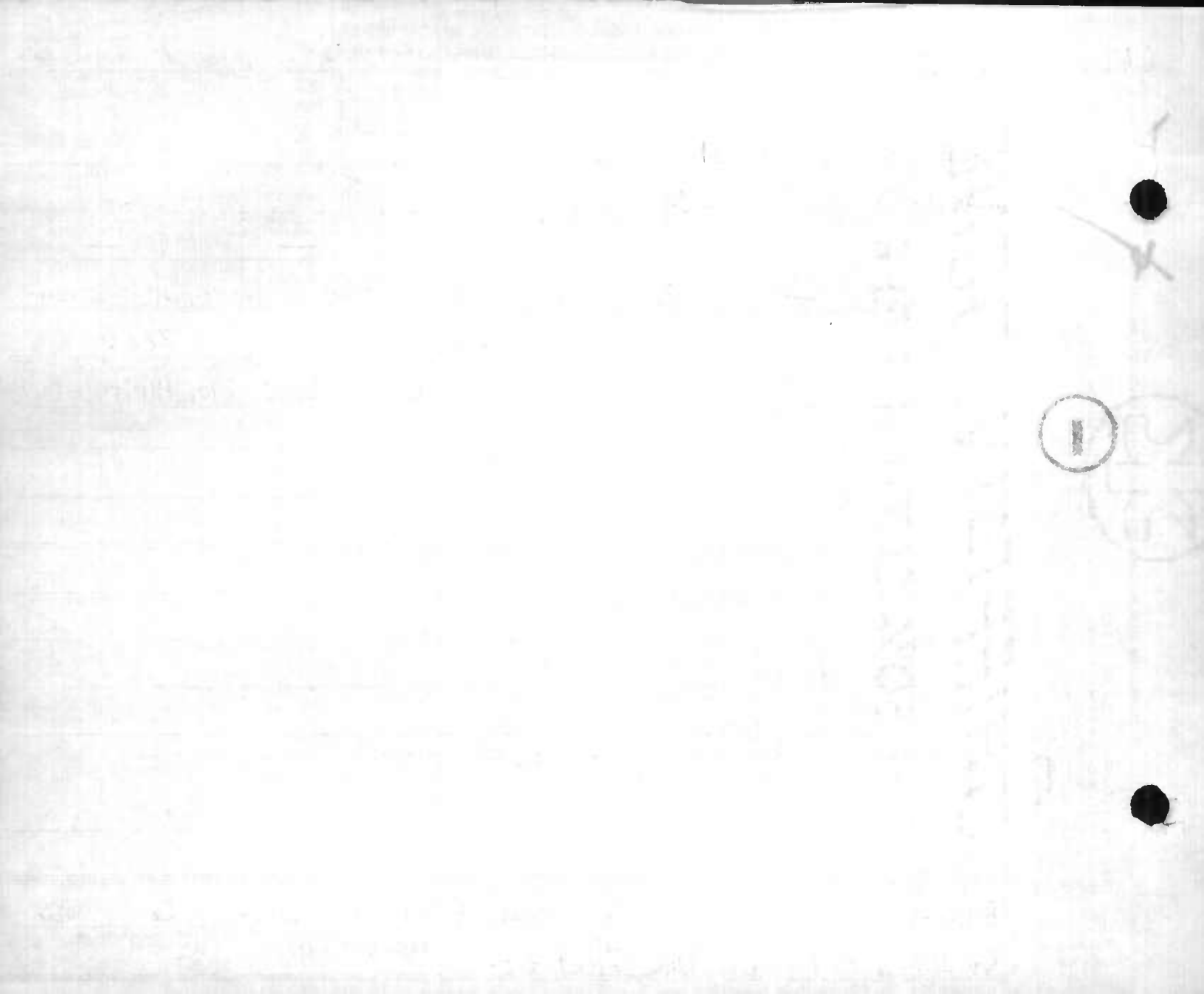
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 12 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT, PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVEMENT OF THE BODY.

BP_____

DHMH - 17

(VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 07838 | |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>1. DECEASED NAME (TYPE OR PRINT) FRANCIS</p> <p>3. SEX MALE</p> <p>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND</p> <p>10. CITY OR TOWN OF DEATH Baltimore</p> <p>13a. STATE MARYLAND</p> <p>14. FATHER'S NAME (TYPE OR PRINT) JOHN</p> <p>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO</p> </div> <div> <p>2. DECEASED NAME (TYPE OR PRINT) SLATER</p> <p>4. RACE CAUC.</p> <p>7b. CITIZEN OF WHAT COUNTRY? USA</p> <p>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2901 Huntington Avenue</p> <p>13b. COUNTY BALTIMORE</p> <p>15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) HELEN</p> <p>16b. SOCIAL SECURITY NO. NO</p> </div> <div> <p>5. DATE OF BIRTH MONTH 5 DAY 31 YEAR 26</p> <p>6. AGE (IN YEARS (LAST BIRTHDAY)) 60 YRS.</p> <p>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD</p> </div> </div> | | | | | | | | | | | | <p>2a. DATE KNOWN OF DEATH ESTIMATED MONTH 3 DAY 23 YEAR 1987</p> <p>2b. HOUR 5:35a</p> | |
| <p>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —</p> <p>12b. KIND OF BUSINESS OR INDUSTRY —</p> | | | | | | | | | | | | | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary emphysema and acute bronchitis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) —
DUE TO, OR AS A CONSEQUENCE OF
(c) —</p> | | | | | | | | | | | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> | |
| <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Cachexia</p> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| <p>22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>.</p> | | | | | | | | | | | | | |
| <p>ACTUAL SIGNATURE Charles P. Kokes</p> <p>EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.</p> | | | | <p>TITLE (SPECIFY) Assistant MEDICAL EXAMINER</p> <p>ADDRESS 111 Penn St., Baltimore, MD 21201</p> | | | | | | | | <p>DATE SIGNED 3-23-87</p> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 3/26/87 | | | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co MD | |
| 24. FUNERAL DIRECTOR NAME KACZOROWSKI ADDRESS FUNERAL HOME 3525 Fleet St. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 23 1987 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |



048169 MAR 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07839
REG. NO.

| | | | | | | | |
|--|--|--|--|---|------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ruth F. Slide | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 21, 1987 | | 2b. HOUR
MIN.
8:45 AM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 5, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YEARS MONTHS DAYS
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belair Convalesarium | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William George | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Appy | | 16. STREET ADDRESS / ZIP CODE
4914 Holder Ave. 21214 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-01-6448 | | 17. INFORMANT
ADDRESS
David A. Slide 4914 Holder Ave. 21214 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Collapse/Heart</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of the Breast</u>
Approximate interval between onset and death: <u>months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Diabetes mellitus Type II; Alzheimer's Disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/27/87</u> to <u>3/21/87</u> , that (I) (we) lost saw the deceased alive on <u>3/12/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Albert B. Bradley</u> | | | | DEGREE
<u>M.D.</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/23/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Albert B. Bradley M.D. | | | | 22e. ADDRESS
4900 Belair Road Baltimore, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
3-24-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 23 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

X



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **07840**

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|-------------------------|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Larry | | MIDDLE
E. | | LAST
Small | | 2a. DATE KNOWN
OF
DEATH
ESTI-
MATED <input type="checkbox"/> 3-10 19 87 | | 2b. HOUR
8:13
a. m. | |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
March 25, 1965 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
21 YRS. | | IF UNDER 1 YR.
MONTHS DAYS
21 | | IF UNDER 24 HRS.
HOURS MIN.
10 | | 2c. DATE
PRONOUNCED
DEAD
3-10 19 87 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital - STU | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
state trooper | | 12b. KIND OF BUSINESS
OR INDUSTRY
St. of Maryland | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Cardiff | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
P. O. Box 65 21024 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Larry G. Small | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jeanne Lawrence | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
214 90 9412 | | 17. INFORMANT
ADDRESS
Larry G. Small, Hagerstown, Md. | | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Injuries
8121
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4:22xx 3-10 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
passenger in auto/tractor trailer impact | |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
highway | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
northbound I-95 near Rt.155, Harve de Grace, | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquest ☐ and in my opinion
death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Dennis F. Smyth* TITLE (SPECIFY)
Assistant MEDICAL EXAMINER DATE SIGNED **3-10-87**

EXAMINER'S NAME (TYPE OR PRINT) **Dennis F. Smyth, M.D.** ADDRESS **111 Penn St., Balto., Md. 21201**

| | | | | | | | |
|--|--|---------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
Mar.13,1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hagerstown, Wash., Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MINNICH FUNERAL HOME
415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Dickinson Radner</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN ITEM 19. THIS CERTIFICATE IS VALID FOR 72 HOURS. IF IT IS NOT EXECUTED WITHIN 72 HOURS, IT MUST BE RE-EXECUTED. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3, RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



048637 MAR 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07841

| | | | | | | | | | |
|--|-------------------------|--|---------------------------------|--|--------------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dorathy Smith | | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH DAY YEAR
3/ 7/ 19 87 | | | | 2b. HOUR
4:50 P M | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
70 YRS. | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
3/ 7/ 19 87 | | 7d. HOUR
4:50 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1313 Wilcox St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1313 Wilcox St. 21202 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 16a. Unkn. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Charles P. Kokes</i> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 3/8/87 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
3-19-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 30 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Anderson-Randall</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN PENCIL IN ITEM 18. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their place is made on page 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07842 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 20. DATE OF DEATH MONTH DAY YEAR | | | |
| Ella L. Smith | | | | 03 17 87 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | |
| F | | White | | 6 24 02 | | 84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. City | | Good Samaritan Hosp | | Housewife/Nurse | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE CITY OR TOWN | | | | 13b. STREET ADDRESS / ZIP CODE | | | |
| Md. Rossview Balto. | | | | 2516 Arbuton Ave. #21250 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| William | | Minnie Campbell | | 16b. SOCIAL SECURITY NO. 212-10-5237 | | | |
| 17. INFORMANT | | ADDRESS | | 17. INFORMANT | | | |
| Mrs. Patricia Spry | | 305 Potomac Ave. - Balto., Md. | | #21237 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) pneumonia | | | | | | | 2-25-87 |
| DUE TO, OR AS A CONSEQUENCE OF (b) subcapital fracture of hip | | | | | | | 2-25-87 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 5:30AM 2-25-87 | | YEAR 19 | | subject fell | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| | | nursing home | | Manor Care Towson, Maryland | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | CERTIFICATION APPROVED BY MEDICAL EXAMINER | | 22c. DATE SIGNED | |
| Randeep Mann | | MD | | ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 3-17-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| RANDEEP MANN | | Good Samaritan Hospital, Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | Mar. 20, 1987 | | Loudon Park Cem. | | City or Town Balto. COUNTY STATE Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| G. Truman Schwab | | 3512 Frederick Ave. # 21229 | | MAR 19 1987 | | | |

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 07843
REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME
<small>(Last, first, middle initial)</small>
GERTRUDE K. SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 27 87 | | | 2b. HOUR
3:45 P.M. | | | | | |
| 3. SEX
F Female | | 4. RACE
W White | | 5. DATE OF BIRTH
MONTH DAY YEAR
05 09 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Med. Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
telephone op. | | 12b. KIND OF BUSINESS OR INDUSTRY
Mfg. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
107 Linden La. 21061 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard Knagff | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jane Eirhardt | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-07-8561 | | | 17. INFORMANT
ADDRESS
William Cook 630 229th, St. Pasadena, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>STAPH. SEPSIS</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>87</u> , to <u>3/27</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Ambrose Woreta</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/27/87</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>AMBROSE WORETA</u> | | | | | 22e. ADDRESS
<u>LIBERTY MEDICAL CENTER</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFIC
Burial | | | 23b. DATE
03/31/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Howard Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Ambrose Funeral Home, Inc., 1328 Sulphur Spr. Rd. | | | | | ADDRESS
21227 | | 25a. DATE OF REGISTRATION
MAR 30 1987 | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Handell</u> | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, investigation of the death may be notified to police.

BP _____

0-1-10

1. The first part of the report is a summary of the work done during the year. It includes a description of the methods used, the results obtained, and a discussion of the significance of the findings. The second part of the report is a detailed account of the experiments conducted, including the objectives, the procedures followed, and the results obtained. The third part of the report is a discussion of the results, including a comparison of the findings with those of other workers in the field, and a discussion of the implications of the results for future work. The fourth part of the report is a conclusion, in which the author summarizes the main findings of the work and states his conclusions regarding the significance of the results. The fifth part of the report is a list of references, which includes a list of the books, articles, and other sources consulted during the course of the work. The sixth part of the report is a list of figures, which includes a list of the tables, graphs, and other illustrations included in the report. The seventh part of the report is a list of tables, which includes a list of the tables included in the report. The eighth part of the report is a list of appendices, which includes a list of the appendices included in the report. The ninth part of the report is a list of footnotes, which includes a list of the footnotes included in the report. The tenth part of the report is a list of acknowledgments, which includes a list of the persons and organizations to whom the author wishes to express his appreciation. The eleventh part of the report is a list of the author's address and other contact information. The twelfth part of the report is a list of the author's other publications. The thirteenth part of the report is a list of the author's other work. The fourteenth part of the report is a list of the author's other interests. The fifteenth part of the report is a list of the author's other activities. The sixteenth part of the report is a list of the author's other accomplishments. The seventeenth part of the report is a list of the author's other awards. The eighteenth part of the report is a list of the author's other honors. The nineteenth part of the report is a list of the author's other titles. The twentieth part of the report is a list of the author's other degrees. The twenty-first part of the report is a list of the author's other diplomas. The twenty-second part of the report is a list of the author's other certificates. The twenty-third part of the report is a list of the author's other licenses. The twenty-fourth part of the report is a list of the author's other permits. The twenty-fifth part of the report is a list of the author's other registrations. The twenty-sixth part of the report is a list of the author's other memberships. The twenty-seventh part of the report is a list of the author's other affiliations. The twenty-eighth part of the report is a list of the author's other associations. The twenty-ninth part of the report is a list of the author's other societies. The thirtieth part of the report is a list of the author's other organizations. The thirty-first part of the report is a list of the author's other groups. The thirty-second part of the report is a list of the author's other teams. The thirty-third part of the report is a list of the author's other clubs. The thirty-fourth part of the report is a list of the author's other leagues. The thirty-fifth part of the report is a list of the author's other associations. The thirty-sixth part of the report is a list of the author's other societies. The thirty-seventh part of the report is a list of the author's other organizations. The thirty-eighth part of the report is a list of the author's other groups. The thirty-ninth part of the report is a list of the author's other teams. The fortieth part of the report is a list of the author's other clubs. The forty-first part of the report is a list of the author's other leagues. The forty-second part of the report is a list of the author's other associations. The forty-third part of the report is a list of the author's other societies. The forty-fourth part of the report is a list of the author's other organizations. The forty-fifth part of the report is a list of the author's other groups. The forty-sixth part of the report is a list of the author's other teams. The forty-seventh part of the report is a list of the author's other clubs. The forty-eighth part of the report is a list of the author's other leagues. The forty-ninth part of the report is a list of the author's other associations. The fiftieth part of the report is a list of the author's other societies. The fifty-first part of the report is a list of the author's other organizations. The fifty-second part of the report is a list of the author's other groups. The fifty-third part of the report is a list of the author's other teams. The fifty-fourth part of the report is a list of the author's other clubs. The fifty-fifth part of the report is a list of the author's other leagues. The fifty-sixth part of the report is a list of the author's other associations. The fifty-seventh part of the report is a list of the author's other societies. The fifty-eighth part of the report is a list of the author's other organizations. The fifty-ninth part of the report is a list of the author's other groups. The sixtieth part of the report is a list of the author's other teams. The sixty-first part of the report is a list of the author's other clubs. The sixty-second part of the report is a list of the author's other leagues. The sixty-third part of the report is a list of the author's other associations. The sixty-fourth part of the report is a list of the author's other societies. The sixty-fifth part of the report is a list of the author's other organizations. The sixty-sixth part of the report is a list of the author's other groups. The sixty-seventh part of the report is a list of the author's other teams. The sixty-eighth part of the report is a list of the author's other clubs. The sixty-ninth part of the report is a list of the author's other leagues. The seventieth part of the report is a list of the author's other associations. The seventy-first part of the report is a list of the author's other societies. The seventy-second part of the report is a list of the author's other organizations. The seventy-third part of the report is a list of the author's other groups. The seventy-fourth part of the report is a list of the author's other teams. 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The eighty-seventh part of the report is a list of the author's other groups. The eighty-eighth part of the report is a list of the author's other teams. The eighty-ninth part of the report is a list of the author's other clubs. The ninetieth part of the report is a list of the author's other leagues. The ninety-first part of the report is a list of the author's other associations. The ninety-second part of the report is a list of the author's other societies. The ninety-third part of the report is a list of the author's other organizations. The ninety-fourth part of the report is a list of the author's other groups. The ninety-fifth part of the report is a list of the author's other teams. The ninety-sixth part of the report is a list of the author's other clubs. The ninety-seventh part of the report is a list of the author's other leagues. The ninety-eighth part of the report is a list of the author's other associations. The ninety-ninth part of the report is a list of the author's other societies. The hundredth part of the report is a list of the author's other organizations.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|--------------------------|--|----------------------------------|--|--|
| 1- FOR STATE REGISTRAR | | 87 07844 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST HELEN | | MIDDLE M. | LAST SMITH | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR |
| | | | | | | | FEB. 13, 1987 | | 8:40 A M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| F. | | BLACK | | JUN. 2, 1900 | | 86 YRS | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | US of A | | | | BALTIMORE, CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | ST. AGNES HOSPITAL | | | | RETIRED | | DOMESTIC | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS / ZIP CODE | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21228 | |
| MARYLAND | | BALTIMORE | | CATONSVILLE | | | | 1 DUNBAR AVE. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| FLETCHER | | | TYLER | | | UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| NO | | | 214 24 2879A | | | MR. LEON TYLER 103 EGES LANE 21228 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible spasm</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dehydration</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | | | | | | | | | ~ 5 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/26/1987</u> to <u>2/13/1987</u> , that (I) (we) last saw the deceased alive on <u>2/13/1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>[Signature]</u> | | | MD | | | | | 2/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| Jose F. Fernandez, MD | | | 900 Caton Ave. Baltimore, Md 21229 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 2/16/87 | | MT. ZION CEMETERY | | BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE | | | | | | MAR 16 1987 <u>[Signature]</u> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07845
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|---|---|---|--|
| DECEASED NAME
(TYPE OR PRINT)
IDA MAE SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 13th, 1987 | | 2b. HOUR
5 A.M. | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
5/14/1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2911 Winchester St. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2911 Winchester St. 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest Bell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Moore | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-20-0575 | | 17. INFORMANT ADDRESS
Donna Smith 2911 Winchester St. | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma fallopian tube
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 19 85 to present 19 87, that (I) (we) last saw the deceased alive on 2 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
S. M. Lufffield M.D. | | 22c. DATE SIGNED
3/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | |
|---|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/18/87 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, B.C. Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Charles A. Rice FSPA 1300 Eutaw Pl. | | 25a. DATE REC'D. BY REGISTRAR
MAR 17 1987 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it should be detached for use as the burial-transit permit. Then please remove cardboard papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



COPIES OF

Handwritten notes and markings, including a large 'X' and various scribbles.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lillian K. Smith | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 16, 1987 | | | 2b. HOUR
4 A M | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 6, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1305 Cedarcroft Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE
Maryland | | | 13b. COUNTY
--- | | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Stackemann | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Gronner | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
1305 Cedarcroft Road 21239 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | | 17. INFORMANT
ADDRESS
Wm. N. Smith Jr. 1907 Cape May Road 21221 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Probable Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>severe COPD</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ryphoscoliosis</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1-2 days
710yr. | | |
| | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>CHF, HBP</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>9-7</u> , 19 <u>83</u> , to <u>present</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>2121</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE,
<u>William E. Randall, Jr.</u> DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
3-16-87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. William E. Randall, Jr. | | | | | | 22e. ADDRESS
1205 York Road | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3-19-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville Balto. Co. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home 6500 York Rd. Bal. Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07841

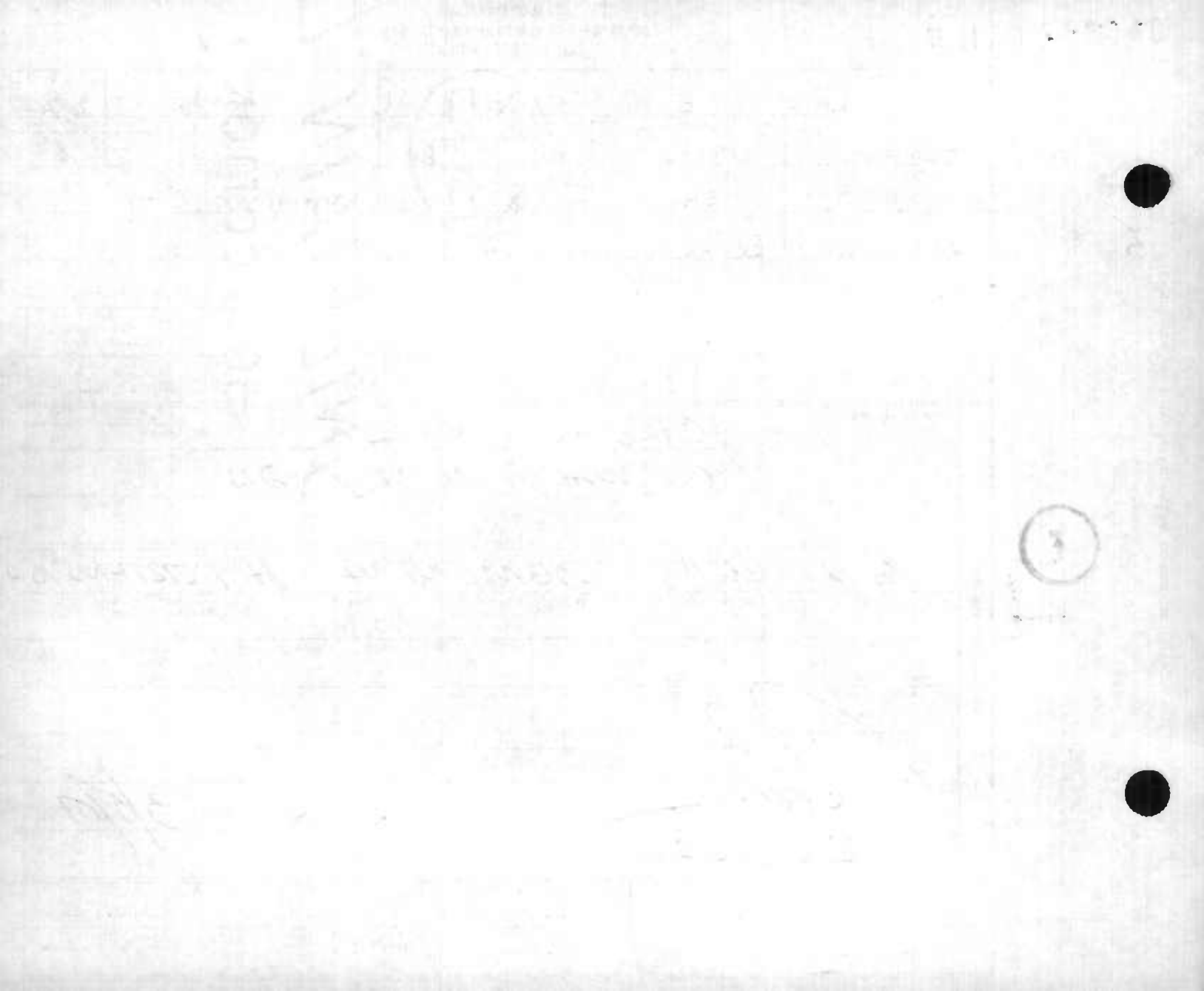
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 above, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Luis E Smith | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 08 87 | | 2b. HOUR
6:20 AM |
| 3 SEX
FEMALE | 4 RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
08 15 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Syracuse, NY | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BELAIR CONVALESCENTIUM | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. City | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank VanBurne | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Parker | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
122-12-8636 | | 17. INFORMANT
ADDRESS
William R. Hobbs, 5911 Eurith Ave. 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY ARTERY D.S.
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.
OLD CVA, DEMENTIA, HYPERTENSION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(STREET, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased die on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
RIVERA | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/6/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RIVERA | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-10-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | |
| 23d. LOCATION
BALTO. | | 23e. COUNTY
Balto., MD | | | |
| 24. FUNERAL DIRECTOR
John G. Miller, Inc., 6415 Belair Rd. 21206 | | | | 25a. DATE RECD. BY REGISTRAR
MAR 10 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP



046868 MAR 12 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07848

FOR
1- STATE
REGISTRAR

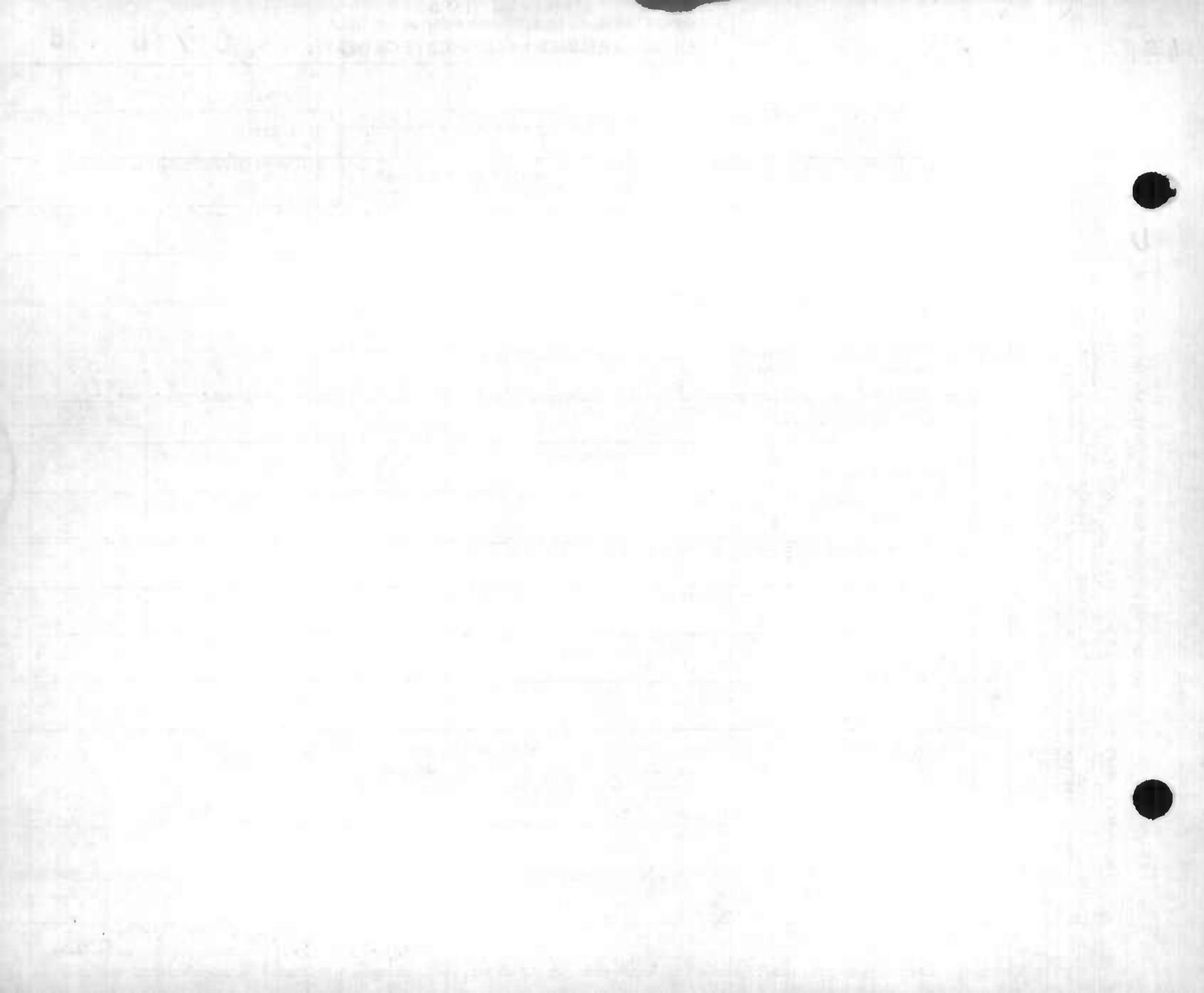
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--------------|----------------|---|--|-----------------|--|---|------|---|--|---|--|--------------------------|--------------|--|--|-------------|--|---|------|--|--------------|---|--|-------------|--|--|------|--|--|-----------------------|--|--|--|------|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Louis | | | MIDDLE
Smith | | | LAST | | | 2a. DATE KNOWN
OF DEATH
ESTI-
MATED | | | MONTH
3-6 | | | DAY
1987 | | | YEAR | | | 2b. HOUR
M | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH
2 | | DAY
23 | | YEAR
16 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
71 YRS. | | IF UNDER 1 YR.
MONTHS | | IF UNDER 24 HRS.
DAYS | | HOURS | | MIN. | | 7c. DATE
PRONOUNCED
DEAD | | | MONTH
3-6 | | | DAY
1987 | | | YEAR | | | 2d. HOUR
3:20
M | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
NC | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
717 Druid Park Lake Drive | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
BETH STEEL | | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
BALTO. | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
717 DRUID PARK LAKE DR. 21217 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST
UNK | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST
DORIS | | | | | | | | | | | | MIDDLE
HAWKINS | | | | | | | | | | | | LAST | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO.
214124413 | | | | 17. INFORMANT
ADDRESS
WILBERT MCDANIELS 3259 O. ST. S.E. WASH., D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Chronic Obstructive Pulmonary Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | | | DATE
SIGNED 3-6-87 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | William M. Zane, M.D. | | | | | | | | | | | | | | | | ADDRESS 111 Penn St. Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
3/11/87 | | | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEMETERY | | | | 23d. LOCATION
CITY OR TOWN
LANSDOWNE | | | | COUNTY
MD | | | | STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME 1101 E. NORTH AVE., | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1987 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 07849 | |
|---|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MAGGIE SMITH | | | 2. DATE OF DEATH MONTH DAY YEAR
3 28 87 | | |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH MONTH DAY YEAR
10 2 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
GEORGE JACKSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
EMMA NAPPY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
— | | | 16b. SOCIAL SECURITY NO.
22524 6552 | | 17. INFORMANT ADDRESS
Ivanhoe Smith Jr. 3837 Bonview Ave. 21213 |
| 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST.
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION.
DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
RECTAL SQUAMOUS CELL CA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3.2 19 87 to 3.2 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) said) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
GUTHRIE | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GUTHRIE | | 22e. ADDRESS
UMCC | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/6/87 | | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto. MD | | 23e. DATE OF DEATH
MAR 05 1987 | | | |
| 24. FUNERAL DIRECTOR NAME
Murch F/H | | ADDRESS
1101 E. NORTH Ave. | | 25. REGISTRY SIGNATURE | |

1

COX COLLOMBE PAPERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07850
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--------------------------------|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Michael Smith | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 15 87 | | | 2b. HOUR
10:20 AM | | | |
| 3. SEX
Male | | 4. RACE
Cauc | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 26 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MO. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bolto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MAXIMIST | | 12b. KIND OF BUSINESS OR INDUSTRY
STEEL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MO. | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK SMITH | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY UNKNOWN | | | 13e. STREET ADDRESS / ZIP CODE
138 N. LAKENWOOD AVE. 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-07-436 | | 17. INFORMANT
ADDRESS
DOUGLAS SMITH 138 N. LAKENWOOD AVE- | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) ARDS
DUE TO, OR AS A CONSEQUENCE OF
(c) Small Bowel Infection | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
82 Days
37 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Renal Failure | | | | | | | | | |
| 19a. DATE OF OPERATION
3/12/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Small Bowel Infection | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/15/87, 19, to 3/15/87, 19, that (I) (we) last saw the deceased alive on 3/15/87, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J. Redo | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-15-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FEDDER | | | | 22e. ADDRESS
St Paul Place, Bolto MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
3/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GREENMOUNT CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR
NAME
B. DABROWSKI / 951 W 2824 E BALTIMORE ST | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
John J. Anderson | | | |

BP

01248

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07851 | |
|--|--|--|--|---|--|--|--|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ridgley G. Smith | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 29 87 | | | 2b. HOUR
6:10 PM | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 13 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
- | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3016 W. GARRISON AVE. # 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Archie Smith | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FRANCIS TURNER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 220-14-6868 | | 17. INFORMANT
ADDRESS
Ruth E. Smith (same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral damage
DUE TO, OR AS A CONSEQUENCE OF
(c) Congestive heart failure | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Possible pneumonia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/18 , 19 87 , to 3/29 , 19 87 , that (I) (we) last saw the deceased alive on 3/29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Rafael E. Espinosa MD | | | | | | DEGREE | | 22c. DATE SIGNED
3/29/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Rafael E. Espinosa | | | | | | 22e. ADDRESS
3001 S. Hanover St. Balt MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
4/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H West 4300 Wabash Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR - 2 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Swenson-Randall | | | |

4/9



30% COTTON FIBRE

APR - 3 1965

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 07852

REG. NO.

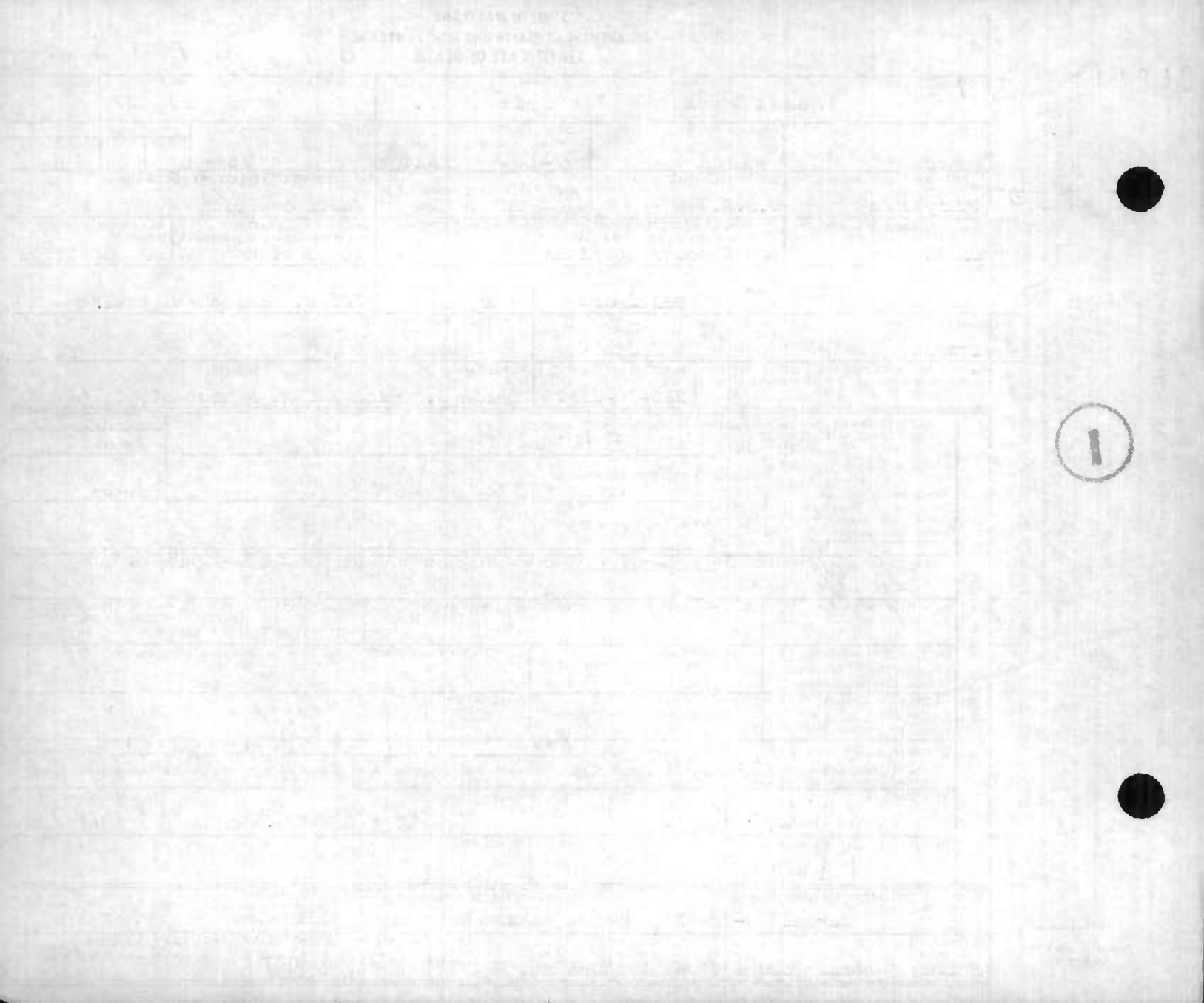
1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Thomas H. Smith, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 23 87 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-10- 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Longshoreman, Steamship Trade | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Trevis Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dora | | | 16. STREET ADDRESS
705 N. Monroe St. 21217 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
218-10-9182 | | 17. INFORMANT
ADDRESS
Pamela D. Smith 705 N. Monroe St. Balto. MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) Smoking
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Seizures | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 27 , 19 87 , to March 25 , 19 87 , that (I) (we) last saw the deceased alive on March 23 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Philip K. Kuntz | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PKuntz | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3-28-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Auburn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Bailey Funeral Home 1348 N. Calhoun St. 21217 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 24 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



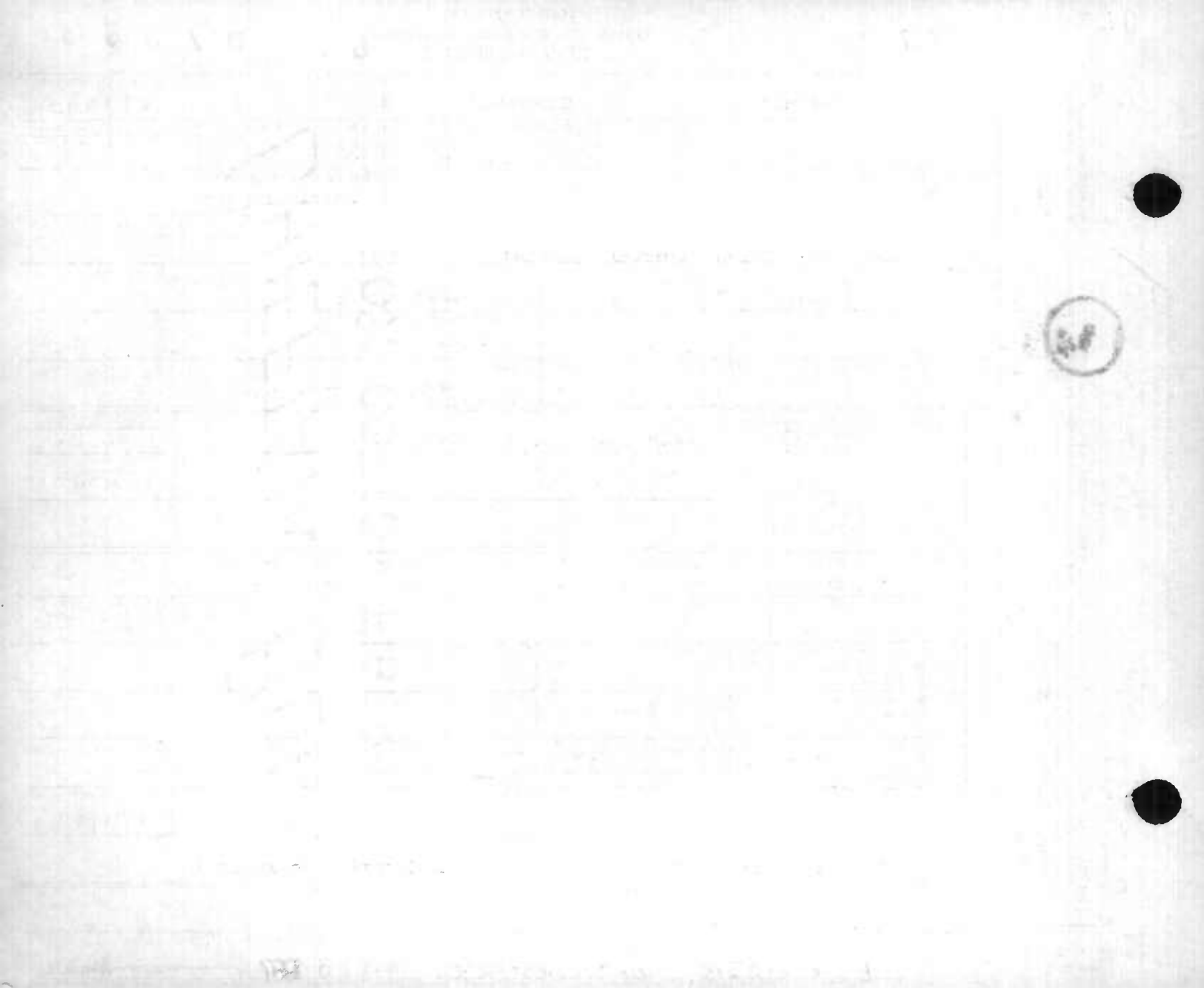
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be issued within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial/transit permit. Their please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 46 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Casimir Smokowski | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b HOUR
3 12 87 1640 PM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1- 10- 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
--- | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Baltimore BA 170 | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Smokowski | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Haluch | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-03-6168A | | 17. INFORMANT ADDRESS
Wanda Grzymala 3208 Rosekemp Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MINUTES | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) UROSEPSIS | | | | | | | | 1 MONTH | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) --- | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
CHF, Chronic Arterial Hypertension, Cerebrovascular Accident | | | | | | | | | |
| 19a. DATE OF OPERATION
NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20 , 19 87 , to 3/12 , 19 87 , that (I) (we) last saw the deceased alive on 3/12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Eva S. Hersh MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
3/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Eva S. Hersh MD | | | | 22e. ADDRESS
Union Memorial Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-16-87 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
John M. Weber & Sons Inc. | | | | ADDRESS
401 S. CHESTER ST. | | 25a. DATE REC'D. BY REGISTRAR
MAR 16 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>James Davidson-Randall</i> | |



046740 MAR 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07854

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) MARY | | FIRST E. MIDDLE S. LAST SMOOT | | 2a. DATE OF DEATH MONTH 3 DAY 6 YEAR 87 | | 2b. HOUR 12P | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH 5 DAY 26 YEAR 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST Charles MIDDLE E. LAST Ebert | | 15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | |
| 16b. SOCIAL SECURITY NO. 214-62-5916 | | 17. INFORMANT ADDRESS Betty Hepple, same as 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulm. arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Pleural effusion (COPD)
DUE TO, OR AS A CONSEQUENCE OF (c) Probable ca of lung
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12pm 3/6/87 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Renal Failure, Umbilical hernia and hernia (GDA) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/2 , 19 85 , to 3/6 , 19 87 , that (I) (we) lost the deceased alive on 3/6 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dr. M. Naar | | DEGREE | | 22c. DATE SIGNED 3/7/87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMATUN M. NAAR | | 22e. ADDRESS 501 Dolphin St, Baltimore MD 21217 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-10-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk., A.A.Co., MD. | | | |
| 24. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy., Baltimore, MD (21225) | | | | 25a. DATE REC'D. BY REGISTRAR MAR 09 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove this certificate. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 below is marked, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
LAND OFFICE
WASHINGTON, D. C.

RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
LAND OFFICE
WASHINGTON, D. C.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL
retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Idell Snowden | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 12 87 | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 23 08 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Northumberland W.A. USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Villa St. Michael Nursing Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4800 Seton Drive 21215 | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Emmanuel Thornton | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Georganna Thompson | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT ADDRESS
Pearl Blackwell 2205 Clifton Ave. 21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>CHRONIC RENAL FAILURE, CONGESTIVE HEART FAILURE</u> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Tasneem Lakhani</u> | | | | | DEGREE
<u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>3/12/87</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>TASNEEM LAKHANI</u> | | | | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
W.C. March F/H West 4300 Wabash Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1987 | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Dickinson-Rodgers</u> | | | | |

